Tennessee

UNIFORM APPLICATION
FY 2008 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/20/2007 - Expires 08/31/2008

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

Table of Contents

State:
Tennessee

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_ FY2008 ___ FY 2008-2009 ___ FY 2008-2010

STATE NAME: Tennessee

DUNS #: 87-889-0425

I. AGENCY TO RECEIVE GRANT

AGENCY: TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

ORGANIZATIONAL UNIT: MENTAL HEALTH SERVICES

STREET ADDRESS: 425 FIFTH AVENUE NORTH, CORDELL HULL BUILDING, THIRD FLOOR

CITY: NASHVILLE STATE: TN ZIP: 37243

TELEPHONE: (615)532-6500 FAX: (615)532-6514

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: VIRGINIA TROTTER BETTS, MSN, JD, RN, FAAN TITLE: COMMISSIONER

AGENCY: TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

ORGANIZATIONAL UNIT: OFFICE OF THE COMMISSIONER

STREET ADDRESS: 425 FIFTH AVENUE NORTH, CORDELL HULL BUILDING, THIRD FLOOR

CITY: NASHVILLE STATE: TN ZIP CODE: 37243

TELEPHONE: (615) 532-6500 FAX: (615)532-6514

III. STATE FISCAL YEAR

FROM: 07/01/2008 TO: 06/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: CAROL M. KARDOS TITLE: MENTAL HEALTH PLANNER

AGENCY: TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

ORGANIZATIONAL UNIT: DIVISION OF RECOVERY SERVICES AND PLANNING

STREET ADDRESS: 425 FIFTH AVENUE NORTH, CORDELL HULL BUILDING, FIFTH FLOOR

CITY: NASHVILLE STATE: TN ZIP: 37243

TELEPHONE: (615)741-3270 FAX: (615)253-1846 EMAIL: Carol.Kardos@state.tn.us

Tennessee

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

EXECUTIVE SUMMARY

Tennessee's medical and behavioral public health system operates under a Medicaid waiver managed care program called TennCare to provide medical and behavioral health services through Managed Care Organizations and Behavioral Health Care Organizations, with both carve-in and carve-out models in various parts of the state. TennCare currently covers nearly 1.2 million persons.

Prior to 2005, TennCare eligibility was automatic for individuals meeting the criteria for Medicaid and extended to other non-Medicaid eligible adults who were uninsured and uninsurable as part of the waiver population. Due to spiraling costs of the program, TennCare eligibility reverted to only Medicaid eligible adults beginning in August 2005. Nearly 168,000 adults have lost eligibility for TennCare. Enrollees under the age of 18 were not included in waiver reduction.

The Department of Mental Health and Developmental Disabilities (DMHDD), in partnership with nineteen community mental health providers, received a state budget allocation to directly contract for a core service package for any adult who lost TennCare eligibility and is assessed as meeting the priority population criteria for Serious Mental Illness (SMI). As of July 2007, approximately 15,300 adults were registered to receive the Mental Health Safety Net (MHSN) services package, and over 85,200 units of service had been provided.

Transformation activities in keeping with the President's New Freedom Commission Goals continue in the areas of anti-stigma efforts, suicide awareness and intervention, consumer-run services, housing and employment initiatives, systems of care, school-based early intervention, consumer and family education and training, and workforce development on evidenced based practices.

In February 2007, by the Governor's Executive Order, the Bureau of Alcohol and Drug Abuse Services was returned to DMHDD from the Department of Health. The DMHDD now serves as the single state authority for receiving and administering federal block grant and state funding for both mental health and substance abuse services.

Mental Health Block Grant funding continues to provide significant support for recovery-oriented, consumer-run services for adults and early intervention services for children and youth. Additionally, these funds allow for the implementation of needed initiatives in mental health and criminal justice interface, older adult services integration, supported housing, consumer and family education and support services, suicide prevention, planned respite, and system of care expansion.

The Appendix file to this plan includes the following documents.

Appendix 1 Planning and Policy Council System Flow Chart
Appendix 2 Map of TN Mental Health Planning Regions
Appendix 3 Mental Health Council By-laws
Appendix 4 DMHDD Organization Chart
Appendix 5 Abbreviations Glossary

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

I hereby certify that Tennessee agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date
PHIL BREDESEN, GOVERNOR

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE GOVERNOR
APPLICANT ORGANIZATION TN DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. Federal Department/Agency:	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ''RFP-DE-90-001.''

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in con- struction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE GOVERNOR
APPLICANT ORGANIZATION TN DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL	DATE SUBMITTED DISABILITIES

SF-424B (Rev. 7-97) Back

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2006	Estimate/Actual FY 2007
$4,802,031	$19,098,430	$18,371,099

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2005	Actual FY 2006	Actual/Estimate FY 2007
$300,186,112	$294,456,890	$280,247,460

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Austin, Stephanie	Providers	Region III Chair	Cumberland Hall of Chattanooga 7351 Standifer Gap Road Chattanooga,TN 37421 PH:423.499.9007 FAX:423.499.9757	stephanie.austin@psysolutions.com
Bacon, Marion	Consumers/Survivors/Ex-patients(C/S/X)	At Large	1081 Court Avenue Apartment A Memphis,TN 38104 PH:901.218.7549 FAX:None	miraclemarian35@gmail.com
Baker, Donna	Consumers/Survivors/Ex-patients(C/S/X)	Region VI Delegate	58 Dixon Street Apartment D-30 Lexington,TN 38351 PH:731.967.3549 FAX:None	donna_baker@hotmail.com
Bertrand, Anita	Others(not state employees or providers)	Mental Health Associations of TN	Director, State Public Policy Office 2416 21st Ave S., Suite 201 Nashville,TN 37212-5318 PH:615.242.7122 FAX:615.242.9637	anitab@mhatn.org
Besmann, Wendy	Consumers/Survivors/Ex-patients(C/S/X)	Region II Delegate	9119 Solway Ferry Road Oak Ridge,TN 37830 PH:865.927.3028 FAX:865.927.0631	wbesmann@tmhca-tn.org
Blackburn, Dick	Providers	TN Association of Mental Health Organizations	TAMHO 42 Rutledge St. Nashville,TN 37210-2043 PH:615.244.2220 FAX:615.254.8331	dblackburn@tamho.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Blackford, Joel	State Employees	Vocational Rehabilitation	DHS Program Coordinator 400 Deaderick St., 11th Floor Nashville,TN 37248-6000 PH:615.313.4898. FAX:615.741.6508	Joel.Blackford@state.tn.us
Bradley, Teena	Family Members of Children with SED	At Large	606 South Lynn Ave Elizabethton,TN 37643 PH:423.542.8151 FAX:None	talishiabradley@charter.net
Bryson, Charlotte	Others(not state employees or providers)	Tennessee Voices for Children	Executive Director 1315 8th Ave S Nashville,TN 37203 PH:615.269.7751 FAX:615.269.8914	Cbryson@tnvoices.org
Carden, Archie	State Employees	Other	Department of Children's Services College Park Drive, Suite A Columbia,TN 38401 PH:931.380.2587 FAX:931.490.6118	Archie.Carden@state.tn.us
Caudill, Jeanne	State Employees	Other	Dept. of Aging and Disabilities Suite 825; 500 Fifth Avenue, N. Nashville,TN 37243 PH:614.741.2056 FAX:615-741.3309	Jeanne.Caudill@state.tn.us
Coats, Marilou	Family Members of adults with SMI	Region III Delegate	3621 Glendon Drive Chattanooga,,TN 37411 PH:423.698.2384 FAX:423.232.2714	Coatsfh@aol.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Cobb, Brad	Family Members of adults with SMI	Region VII Delegate	P O Box 40168 Memphis,TN 38174 PH:901.725.0305 FAX:901.725-0306	bcobb35@yahoo.com
Copas, Linda	State Employees	Education	DOE, AJ Tower, 5th floor 8th and James Robertson Nashville,TN 37243 PH:615.741.7790, FAX:615.532.9412	Linda.Copas@state.tn.us
Diehl, Sita	Family Members of Children with SED	NAMI-Tennessee	Executive Director, NAMI-TN 1101 Kermit Drive, Suite 605 Nashville,TN 37217 PH:615.361.6608 FAX:615.615.361.6698	sdiehl@namitn.org
Dillon, Debra	Providers	Region VII Chair	Southeast MHC 3810 Winchester Road Memphis,TN 38181 PH:901.312.7518 FAX:901.369.1433	debra.dillon@semhcinc.com
Ewing, Rhonda	Family Members of adults with SMI	Region VI Chair	239 North Parkway Suite C Jackson,TN 38305 PH:731.984.8599 FAX:731.984.8575	rewing@tnvoices.org
Falkner, Sherry	Family Members of adults with SMI	Region I Delegate	3608 Cimarron Drive Johnson City,TN 37601 PH:423.282.8844 FAX:509.461.7596	sfalkner@namitn.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Fox, Anthony	Consumers/Survivors/Ex-patients(C/S/X)	TN Mental Health Consumers Association	Executive Director, TMHCA 480 Craighead Street, Suite 200 Nashville,TN 37204 PH:615.250.1176 FAX:615.383.1176.	afox@tmhca-tn.org
Godsey, Teresa	Consumers/Survivors/Ex-patients(C/S/X)	Region I Delegate	2802 Plymouth Road, #209 Johnson City,TN 37601 PH:423.926.1693 FAX:None	tgodsey@juno.com
Griffin, Jim	Others(not state employees or providers)	Region II Delegate	7921 Neubert Springs Road Knoxville,TN 37920 PH:865.609.2490 FAX:865.609.2543	jgriffin@tnvoices.org
Harper, Brenda	Providers	Region V Chair	Volunter-Cumberland MHC 1404 Winter Drive Lebanon,TN 37087 PH:615.444.4300 FAX:615.449.2734	bharper@vbhcs.org
Harrington, Ben	Others(not state employees or providers)	CHAIR	Executive Director, MHA of East TN P O Box 32731 Knoxville,TN 37930-2731 PH:865.584.9125 FAX:865.824.0040	ben@mhaet.com
Lawson, Vickie	State Employees	Social Services	DHS, 400 Deaderick Street, 14th Floor Nashville,TN 37243 PH:615.313.4784 FAX:615.532.9956.	Vickie.Lawson@state.tn.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lewis, Linda	Consumers/Survivors/Ex-patients(C/S/X)	Region VI Delegate	207 Forest McKenzie,TN 38201 PH:731.352.7833 FAX:None	llewis38201@yahoo.com
McKenzie, Mamie	Family Members of adults with SMI	Region IV Chair	1315 8th Ave S, Nashville,TN 37203 PH:615.269.7751 FAX:615.269.8914.	mmckenzie@tnvoices.org
McLennan, Mary	State Employees	Housing	THDA 404 James Robertson Parkway Nashville,TN 37243 PH:615.741.9671 FAX:615.741.9634	mmcLennan@thda.org
Miller, Jeanine	State Employees	Criminal Justice	Department of Correction 320 6th Avenue North, 4th Floor, Nashville,TN 37243 PH:615.741.1000 FAX:615.741.1055	Jeanine.C.Miller@state.tn.us
Myszka, Michael	State Employees	Medicaid	Bureau of TennCare 706 Church St, 6th Floor Nashville,TN 37247 PH:615.741.8142 FAX:615.741.0064.	Michael.Myszka@state.tn.us
O'Neal, Linda	State Employees	Other	TN Commission on Children and Youth 710 James Robertson Parkway Nashville,TN 37243-0800 PH:615.741.2633 FAX:615.741.5956.	Linda.Oneal@state.tn.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Page, Joe	Providers	Region I Chair	Frontier Health Services 26 Midway Street Bristol,TN 37620 PH:423.989.4691 FAX:423.467.3710	jpage@frontierhealth.org
Petty, Steve	Providers	Region II Chair	Peninsula Behavioral Health P O Box 789 Louisville,TN 37777-0789 PH:865.970.9800 FAX:865.970.1884	spetty@covhlth.com
Reigel, Karen	Consumers/Survivors/Ex-patients(C/S/X)	Region V - Delegate	P O Box 3635 Clarksville,TN 37043 PH:931.905.0933 FAX:931.906.0355	katz47R@yahoo.com
Secrest, Warren	State Employees	Other	Dept. of Labor and Workforce Development 1610 University Avenue Knoxville,TN 37921 PH:865.594.2756 FAX:865.594.2767	Warren.Secrest@state.tn.us
Stewart, Logan	Consumers/Survivors/Ex-patients(C/S/X)	At Large (Transitional Youth)	809 Norwalk Nashville,TN 37214 PH:615.361.6608 FAX:None	furubafan@comcast.net
Stewart, Roger	Family Members of Children with SED	At Large	809 Norwalk Drive Nashville,TN 37214 PH:615.361.6608 FAX:None	rstewart@namitn.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Thompson, Verdine	Consumers/Survivors/Ex-patients(C/S/X)	Region III Delegate	1110 Sioux St Athens,TN 37303 PH:423.745.4796 FAX:423.745.1797.	jwvft@comcast.net
Tift, Linda	Family Members of adults with SMI	Region V Delegate	4080 Caney Creek Lane Chapel Hill,TN 37034 PH:931.364.4080 FAX:None	lindatift@united.net
Totten-Emerson, Gary	Consumers/Survivors/Ex-patients(C/S/X)	Region IV Delegate	1517 16 Avenue S Nashville,TN PH:615.426.6144 FAX:	Gary.Totten-Emerson@centerstone.org
Whitlock, Marthagem	State Employees	Mental Health	Division of Policy and Legislation 425 Fifth Avenue North Nashville,TN 37243 PH:615.532.5744 FAX:615.532.6514	Marthagem.Whitlock@state.tn.us
Williams, Pat	Family Members of adults with SMI	Region IV Delegate	4301 Elkins Avenue Nashville,TN 37209 PH:615.386.0204 FAX:615.259.7594	phwilliams2@comcast.net
Winston, June	Providers	Region VII Delegate	Lowenstein House 821 Barksdale Memphis,TN 38114 PH:901.274.5486 FAX:901.278.6927	JWins@aol.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Wood, Carla	Family Members of Children with SED	At Large	12 Wright Road Fayetteville,TN 37334; PH:931.438.2562 FAX:None	toddwood4587@bellsouth.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	43	
Consumers/Survivors/Ex-patients(C/S/X)	10	
Family Members of Children with SED	4	
Family Members of adults with SMI	7	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers)	4	
TOTAL C/S/X, Family Members and Others	25	58.14%
State Employees	11	
Providers	7	
Vacancies	1	
TOTAL State Employees and Providers	18	41.86%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

As part of integrating the Division of Alcohol and Drug Abuse Services into DMHDD, two slots are currently being held open. DMHDD is currently seeking individuals willing to self-identify as consumers with a co-occurring disorder of mental illness and subtance abuse who wish to participate.

Tennessee

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

3. Planning Council Charge, Role and Activities

The TDMHDD has a three-tiered system of advisory councils. A council system flow chart and regional map are included with this application as Appendices 1 and 2. There are seven Regional Mental Health Planning and Policy Councils (RMHPC) and Regional Developmental Disabilities Planning and Policy Councils (RDDPC). Each regional council has delegates that represent the region on state planning and policy councils for mental health (MHPC) or developmental disabilities (DDPC). Current or previous state-level council members serve on the Department of Mental Health and Developmental Disabilities Planning and Policy Council (MHDDPC), which replaced the Department's Board of Trustees in 2001.

DMHDD has actively recruited cultural minorities, transitional age (16-22) youth, and caregivers of young children with SED for Council membership. In FY07, vacant at-large membership positions were not filled so that recruited members could be appointed throughout the year. Using this strategy, we have increased our family members of children with SED representation from 2% to 9%. The FY08 Council roster also reflects increased minority representation (14%) and includes our first transitional youth member (age 16).

With the return of Alcohol and Drug Abuse Services to the DMHDD, representatives of primary A&D services will be added to the MHDDPC and RMHPCs for FY08. In keeping with the dual role of the MHPC – its federal mandate and its responsibilities under State statute – two at-large slots for FY08 are reserved for A&D providers and/or consumers, preferably those with an interest and experience in services for individuals with co-occurring disorders. This number may be increased in future years.

Pursuant to Public Law 102-321 and Tennessee Code Annotated, Sections 33-2-202 and 33-2-203, the principal purpose of the MHPC is to provide citizen participation to assist and advise the DMHDD in planning, policy development and oversight of the state's comprehensive mental health service system for persons of all ages with mental health needs, including adults with SMI and children and youth with SED. The following is excerpted from Article II of the MHPC bylaws.

2.1 The Council shall review the annual Mental Health Block Grant plan and make recommendations.

2.2 The Council shall serve as an advocate for adults with SMI and for children with SED and other individuals with mental illnesses or emotional problems by providing public mental health education and awareness activities and promoting non-discriminatory policies and practices.

2.3 The Council shall monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state including review of monitoring and evaluation reports pertaining to the implementation of the state's mental health program.

2.4 The Council shall advise the DMHDD Planning and Policy Council on the Three Year Plan including the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families, and such other matters as the Commissioner of DMHDD or the DMHDD Planning and Policy Council may request.

2.5 The Council shall provide information and advice to the Department on policy, formulation of budget requests, development and evaluation of services and supports, and on other matters as requested by the Commissioner of DMHDD or the DMHDD Planning and Policy Council.

A copy of the complete MHPC Bylaws is attached as Appendix 3.

The MHPC, through its statewide representative membership and committees, plans and advises on efforts in the areas of consumer and family advocacy, cultural competence, criminal justice, service delivery, managed care, discrimination, housing, employment, public policy, and planning. Data and performance reports are reviewed on a variety of service initiatives and as requested. Information on regional funding allocations, service utilization, outcomes, and program compliance are made available for review.

The Council further reviews and advises annually on both the Block Grant Plan and the Department's Three Year Plan and has member participation on the MHDDPC.

In addition to routine activities of reviewing Block Grant and state funding allocations and services, available data reports, statewide needs assessment information and proposed annual Three Year Plan revisions, FY07 Council activities focused on the following:

- expanding and monitoring access to the Mental Health Safety Net Program;
- the smooth transition of consumers to a newly established carve-in model managed care program in Middle Tennessee;
- learning about the data and information capability of the Tennessee Outcomes Measurement System (TOMS) and its utilization for planning;
- legislative advocacy on a number of bills related to, or with potential impact on, the behavioral health system; and
- monitoring recovery-oriented service initiatives within the managed care system.

The MHPC continuously advocates for transformation and recovery focused activities through managed care service system monitoring, development of and participation in community events, and recommendations to the Department and the Legislature. Members of the Council are active both in state and regional initiatives promoting non-discrimination in housing and employment, the reduction of social stigma, and interagency collaboration toward integrated services.

During FY07, various Council members played active roles as planners and/or participants in a statewide Recovery and Resiliency Conference, EBP Consultation on Supported Employment and Illness Management and Recovery, suicide prevention in the minority community, an anti-stigma arts awareness campaign, peer specialist certification activities, and the expansion of certain federal programs, such as the Individual Development Account Program (IDA), to mental health consumers.

Tennessee

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

4. Public Comments on State Plan

Public comment is solicited through availability of the draft plan to members of the Statewide Mental Health Planning and Policy Council, the seven Regional Mental Health Planning and Policy Councils, the Departmental Mental Health and Developmental Disabilities Council, DMHDD Core Team staff and others requesting a copy. This effort directly reaches nearly 300 individuals but, through copying and sharing with various constituency groups, reaches a much broader audience.

For the working draft of the 2008 Block Grant Plan, web-based "read and comment" access instructions were forwarded to members of planning councils and consumer and family advocacy groups in July 2007, instructions were posted on the Department's web site for general public access, review and comment on July 20, 2007, and an electronic copy was distributed to State Mental Health Planning and Policy Council members on July 27, 2007 for discussion and formal review at the August 17, 2007 meeting.

Any questions and/or comments not entered directly on the Block Grant web site may be directed to the Council Chair, MHDD Commissioner, or to the Mental Health Planner responsible for preparing the grant.

Mental Health Planning Council comments or recommendations are generally forwarded to the Council Chair for inclusion into the Council response letter that accompanies the Block Grant Plan submission. A copy of the most current Community Mental Health Block Grant Plan and Implementation Report is maintained on the Department's web site.

Tennessee

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

PART C. STATE PLAN

SECTION I. Description of the State Service System

Overview of the Mental Health System

The state system of public behavioral health care for adults and children and youth consists of three major service delivery entities.

1. TennCare and the TennCare Partners Program (TCPP)

TennCare, a Medicaid waiver program, began in January 1994 as a carve-in model to provide medically necessary physical and behavioral health care services through various Managed Care Organizations (MCOs). In July 1996, behavioral health services were carved-out out to Behavioral Health Organizations (BHOs), creating the TCPP. With the advent of the TCPP, fiscal responsibility for traditional clinical behavioral health services transitioned from DMHDD to the Department of Health, Bureau of TennCare. Administrative oversight of the Bureau of TennCare has subsequently been transferred from the Department of Health to the Department of Finance and Administration.

From 1994 to 2005, TennCare eligibility was extended to non-Medicaid eligible adults who were uninsured and/or uninsurable and TennCare covered up to 1.6 million Tennesseans. Due to spiraling costs, TennCare reform resulted in a reduction in the waiver population during FY06. Only adults meeting criteria for Medicaid maintained TennCare eligibility. As of August 2005, nearly 191,000 adults were scheduled to lose eligibility for TennCare, including 21,000 assessed as SMI. As of June 30, 2007, less than 1.2 million persons in Tennessee remained covered under TennCare.

Behavioral health services in the TennCare benefit package include: Inpatient and Outpatient Psychiatric Treatment; Inpatient, Residential and Outpatient Substance Abuse Treatment Services; Pharmacy and Laboratory Services; Mental Health Case Management; 24-Hour Residential Treatment; Psychiatric Rehabilitation Services; 24/7 Crisis Response Services and Crisis Respite; and Transportation (to covered services as medically necessary for enrollees lacking accessible transportation). Limits apply to some services.

Currently, TCPP services are provided under contract with Managed Care Contractors (MCCs) and both carve-in and carve-out models are used. More than 1,200 providers (including agencies, groups and individual providers) are a part of the managed behavioral health care system. Historically, about 10% of adult and 4% of child and youth TennCare enrollees meet the criteria for SMI or Serious Emotional Disturbance (SED).

2. The Department of Mental Health and Developmental Disabilities (DMHDD)

Managed Behavioral Health Care

The Division of Managed Care (DMC) is responsible for contracting, monitoring, and oversight of the MCCs that participate in the TCPP. DMC currently oversees a total of five service area contracts with three MCCs. DMC also oversees the designation of priority populations, monitors contract compliance, and assesses the use of clinical best practice guidelines.

Mental Health Safety Net Services

Anticipating the loss of TennCare benefits for 21,000 adult service recipients, DMHDD, in partnership with community providers and advocates across the state, developed a core service package called the Mental Health Safety Net (MHSN); a service package designed to meet basic medication and treatment needs. A state "safety net" budget allocation to bolster public health services included funding for the MHSN program.

Beginning in FY06, DMHDD directly contracted with Community Mental Health Agencies (CMHAs) to provide MHSN services to any of those identified 21,000 adults with SMI. Eligibility has since been expanded to any adult who lost TennCare due to waiver reform and is assessed as meeting the priority population criteria for SMI. Disenrollees may register with any one of nineteen CMHAs to receive services.

The MHSN benefit package includes: Assessment, Evaluation, Diagnostic, and Therapeutic Interventions; Mental Health Case Management; Psychiatric Medication Management; Laboratory Services Related to Medication Management; and Pharmacy Assistance and Coordination. The program also supports pharmacy services that include discounts on generic and brand name drugs plus one atypical antipsychotic drug per month with a minimal co-pay.

Of the approximately 168,000 adults officially disenrolled from TennCare as of March 2007, nearly 12% have registered for MHSN services. Of the original 21,000 adults with SMI, approximately 78% have registered. As of July 2007, 15,361 adults have received over 85,200 units of service under this program.

Non-Managed Care Services

DMHDD maintains state and federal grant-funded contracts with forty-six private, non-profit CMHAs and other organizations to provide services that are either not available or not fully supported through the TCPP. These include a variety of prevention, early identification and intervention, educational, support and recovery based services as well as adult and juvenile forensic evaluations. Dollars further support initiatives in housing, employment, integrated services, criminal justice, planned respite and systems of care. A full description of supplemental services provided is included in Section III, Criterion 1, Current Activities, in the taxonomy of services in both the adult and Children and Youth sections.

Mental Health Services is also a recipient of a number of federal grants in the areas of services to the homeless, integrated services for older adults with substance abuse, integrated treatment for abusers of methamphetamine, systems of care, suicide prevention, and data infrastructure development.

Substance Abuse Services

In February 2007, by Governor's Executive Order, the Bureau of Alcohol and Drug Abuse Services was returned to DMHDD from the Department of Health. The renamed Division of Alcohol and Drug Abuse Services (DADAS) contracts with community providers for substance abuse treatment and prevention services utilizing state funding and the Substance Abuse Prevention and Treatment Block Grant.

The DADAS functions through five offices and two major program areas. These include the Offices of Administrative Services, Finance and Systems, Prevention Services, Managed Care Services, and Treatment Services and Program Design.

Program areas are related to the Alcohol and Drug Addiction Treatment Fund for DUI offenders and Training and Education Services.

Special project initiatives occur in the areas of Co-Occurring Disorders, the Tennessee A&D Prevention Outcome Longitudinal Evaluation (TADPOLE), the Tennessee Outcomes for Alcohol and Drug Services (TOADS), the Tennessee Access to Recovery Program, and the Strategic Prevention Framework-State Incentive Grant Gambling Initiative.

Co-Occurring Disorders (COD)

DMHDD uses the term COD to describe individuals diagnosed with both a mental disorder and an alcohol and/or drug abuse or dependence disorder.

The Department is active in developing strategies to better serve those with COD through statewide, regional and local contracts with providers to:

- educate professionals about co-occurring disorders and the need for integrated services;
- inform the public about co-occurring disorders and how to access services;
- develop more integrated treatment services for individuals with co-occurring disorders and their families; and
- provide case management services to persons with co-occurring disorders who do not have insurance or an ability to pay.

It is anticipated that additional opportunities for better integration of services for those with co-occurring disorders of mental illness and substance abuse will accompany the return of Alcohol and Drug Abuse Services to the DMHDD.

State Psychiatric Inpatient Services

DMHDD operates five fully JCAHO accredited Regional Mental Health Institutes (RMHIs) with a current total capacity of 942. That number includes 410 acute and 450 sub-acute beds for adults, 52 beds for children and youth, and 30 secure forensic beds.

Lakeshore Mental Health Institute (Knoxville), Moccasin Bend Mental Health Institute (Chattanooga), and Memphis Mental Health Institute provide in-patient psychiatric services for adults; Middle Tennessee Mental Health Institute (Nashville) and Western Mental Health Institute (Bolivar) provide in-patient psychiatric services for both adults and children and youth.

Most (92%) RMHI admissions are on an emergency involuntary basis, with statute requiring admission regardless of capacity. A variety of court-ordered inpatient evaluation and treatment services are also provided. The RMHIs provide psychiatric services based upon the demonstrated and emerging best practices of each clinical discipline.

Forensic Services

The DMHDD Office of Forensic & Juvenile Court Services provides oversight of and has responsibility for the adult and juvenile forensic services for the State of Tennessee. Office staff are responsible for the development and monitoring of performance standards for inpatient and outpatient services, providing forensic consultation to service providers and court officers, conducting training for certification for forensic evaluators, and overseeing contractual, billing, and payment requests.

3. The Department of Children's Services (DCS)

DCS is responsible for the provision and oversight of services to children in or at risk of state custody. Services provided by DCS include child protective services, foster care, adoption, programs for delinquent youth, probation, aftercare and treatment services, and rehabilitation programs for identified youth.

The majority of children and youth in DCS custody are enrolled in TennCare. DCS provides financial support for necessary behavioral health services not covered by TennCare or for those without financial support.

Children in foster care or otherwise in state custody are highly likely to have special health care needs, including behavioral health and developmental needs. The Tennessee Centers of Excellence (COE) system consists of three regional centers and is designed to support DCS in integrating placement, family, health, mental health and developmental needs into a comprehensive, coordinated care plan based on the child and family's unique needs.

The COEs also provide consultation to pediatricians, psychiatrists and other health care providers, participate in case conferences, and provide training to community providers and agencies with the intent of improving the knowledge and skills of those serving children in, or at risk of, state custody and their families.

Tennessee

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

FY07 Summary of Areas Needing Attention and Accomplishments

ADULT service needs included in the 2007 plan were identified by an annual needs assessment process. They included: 1) televideo capacity at RMHIs to allow evaluation and consultation regarding persons being assessed for involuntary commitment; 2) expansion of the criminal justice/mental health liaison project, 3) full funding of the Creating Jobs Initiative, 4) transportation initiatives, 5) co-occurrence services training and coordination, 6) conservatorships for persons requiring oversight to facilitate discharge from inpatient care, and 7) an older adult mental health services directory.

Televideo Capacity:
DMHDD promotes the use of telemedicine to increase response time for diagnosing patients, reduce stressors on the persons with a potential mental illness, and reduce transportation costs. Currently, forty-two telemedicine sites have the capacity to provide increased access and availability to physician services. Televideo assessments for involuntary emergency admissions is in place at one state psychiatric hospital to better coordinate the admissions process and eliminate unnecessary travel, time and stress for consumers, family and law enforcement.

To enhance the use of this technology, DMHDD developed a telemedicine work group to assess barriers to utilization and promote telemedicine services statewide. A survey was conducted with CMHAs and RMHIs across the state. The information from these surveys is being reviewed to determine next steps in overcoming barriers to increase utilization of telemedicine services for the purpose of improving access and availability to behavioral health services.

Criminal Justice Project Expansion:
The criminal justice mental health liaison program has expanded to eighteen projects serving twenty-three counties, providing services to adults with behavioral health needs in jails, diversion activities, referral and follow-up. Both urban and rural jails are included in the project. Liaison staff provide statewide education and training for law enforcement and court personnel. A budget improvement request for additional positions was not funded.

Funding for Creating Jobs Initiative::
The Creating Jobs Initiative kick-off occurred in cities across Tennessee in FY06 with a goal of increasing the number of persons with mental illness employed statewide by 2,010 persons by 2010. Budget improvement requests for FY07 and FY08 were not funded; a limited program continued with the use of mental health consumer VISTA volunteers through FY07. Local advocacy efforts were successful in obtaining a legislative allocation to fully implement the project at one site in the Chattanooga area. Collaborative efforts with vocational rehabilitation services staff continue to improve access to employment for persons with mental illness.

Transportation Initiatives:
DMHDD assesses and develops an action plan to address the needs of persons who attend Peer Support Centers, including providing financial support to agencies to assist with transportation to the Center and community activities of interest to consumer members. Staff have been active in the Department of Transportation's statewide planning efforts and will convene stakeholder meetings across the state in FY08 to assess and prioritize local transportation needs.

Co-occurrence Services Training and Coordination:
The DMHDD Coordinator of Co-occurring Disorder (COD) services works closely with other agencies and state departments on COD issues for adults and children. During FY07, staff participated in the following activities.

- COD Education, Training and Consultation was provided by Dual Diagnosis Management to 235 RMHI staff.
- A Resource Directory for COD was developed and is maintained on the Department's website.
- COD staff participates as an Advisory Board Member and liaison to the Tennessee Adolescent Coordination of Treatment Grant Project.
- COD staff meets quarterly with Division of Alcohol and Drug Services staff to share information and plan activities concerning COD issues.
- Education and training was provided to ten providers responsible for delivering specialized COD case management services.

Conservatorship Availability:
A pilot project was begun in the Knoxville area to provide conservators for individuals in the RMHI who, because of their mental illness, lack capacity to make informed decisions and are clinically ready for discharge to the community. A conservatorship task force was convened to discuss programmatic and development issues. The task force has since developed a training manual. Recruitment and training efforts began in August 2007, and complete start up is anticipated in late September. The project is expected to serve about ten mental health consumers in 2008.

Older Adult Services Directory:
The Council of Community Services already publishes a resource directory for older adult services for the Middle TN area. Staff from the Division of Special Populations are in the process of gathering resource information, and on-line directories are planned for services in the East and West areas of the state. The directory will be published electronically. While staff and advocates believe that printed copies are important, especially for older adults, no funding resource has been identified to cover printing costs.

FY07 Summary of Areas Needing Attention and Accomplishments

CHILDREN AND YOUTH service needs included in the 2007 plan were identified by an annual needs assessment process. They included: 1) continuation of Peer Power, an in-school violence prevention program, 2) expansion of BASIC, an early identification and intervention program, and 3) expansion of the school-based mental health liaison program.

Peer Power: The Peer Power program, for grades 4-8, strengthens youth resiliency through social skill enhancement. The program served thirty-eight classrooms in seven counties in Middle Tennessee with 822 hours of direct classroom services and 17,000 contacts in FY06. Pre/post test results show a 65% reduction in discipline referrals, a 90% improvement in student behavior in at least one or more documented problem area, and a 90% overall positive student satisfaction rate. A FY07 improvement budget request to continue this previously federally funded program was approved.

Expansion of BASIC: BASIC (Better Attitudes and Skills in Children) is a mental health prevention, early identification and intervention program for grades K-3 to enhance awareness and capacity of school personnel to respond to the mental health needs of children and reduce the incidence of adolescent and adult behavioral health problems. Currently, BASIC staff are providing services to forty-three school sites in thirty-nine high-risk rural counties. Children and youth stakeholders have advocated for expansion of BASIC to every elementary school in the state. Block grant funding fully supports this program. Given the recent decreases in that allocation and the lack of state improvement dollars, expansion has not been possible.

School-based Mental Health Liaisons: Pass-through funding from the Department of Education to DMHDD supports two school-based Mental Health Liaison positions in Davidson County (Nashville area) to provide face-to-face consultation with classroom teachers to assist them in structuring the classroom to enhance the learning environment for children with SED. A budget improvement request to expand the number of mental health liaison positions was not approved.

Tennessee

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues

The Governor's Cover Tennessee proposal began strategies during FY07 to help individuals who are uninsured in Tennessee. A number of these initiatives give priority to persons losing TennCare during waiver reform.

- CoverRx provides affordable medication to low income, uninsured citizens between the ages of 19 and 64 with income below 250% of the federal poverty level. To date, coverage has been provided for more than 21,000 adults.

- AccessTN provides a comprehensive health insurance plan for seriously ill adults who have been turned down by insurance companies as uninsurable. There is a premium cap and assistance for individuals with low income. Enrollment is currently capped at 6,000 with the first 4,500 slots set aside for TennCare disenrollees.

- CoverTN provides basic health coverage for uninsured workers of small businesses with 25 or fewer employees, a qualifying percentage of whom earn 250% or less of the federal poverty level. The monthly premium is split between the state, the worker, and the employer. Since the program opened in March 2007, 3,800 employers and nearly 10,000 workers have signed up for CoverTN. CoverTN is expected to expand coverage to businesses employing up to 50 employees in 2008.

- CoverKids extends low-cost comprehensive health insurance to pregnant women and uninsured children age 18 and under, with benefits under Blue Cross/Blue Shield modeled after the state employee health plan.

  Enrollment has been slow since it began in April 2007. Numerous enrollment events are planned across the state in an effort to educate the public about the benefits of this program. Every child who attends school will take home a CoverKids application in a statewide enrollment campaign to get health insurance coverage to uninsured children. Working with the Department of Education, CoverKids is coordinating the delivery and distribution of one million program applications to Tennessee's public schools. The applications will be included in each child's back-to-school packet. Each application will include a postage-paid, self-addressed envelope to make it easy for parents to return completed applications.

  CoverKids representatives will also be working with the Department of Revenue to host enrollment events across Tennessee, leading up to and during the state's sales tax holiday weekend in August. Cover Tennessee officials have also asked Governor Bredesen to proclaim the week of August 5th as CoverKids week in Tennessee.

A further development is the return of substance abuse services oversight to the DMHDD. It had been moved to the Department of Health (DOH) in 1991 as an initial step in a failed attempt to merge mental health services into the DOH. Council members and various stakeholders successfully protested that merger and have made recommendations to the administration for this reintegration for several years. The move will facilitate coordinated services, communication, and the development of evidenced based programs and treatment options that focus on the whole person, including better integration of services for adults and children with co-occurring disorders.

The new carve-in managed care contract for the Middle Tennessee area was finalized during FY07, with the transition of services beginning on April 1, 2007. Approximately 337,000 service recipients were successfully transitioned to one of two new health plans. As a part of the transition process, funding was made available for the development of new Crisis Stabilization Units in Nashville and Cookeville, and a crisis respite program with supports of transportation, medical evaluations, and additional clinical services in the Columbia area in Region V. In order to assure the continuation of needed services, suspender funding was allocated to build-out capacities in crisis services, transitional support, supervised and independent housing, and to maintain a variety of service and support initiatives funded by the MCC previously serving the area.

While there is a desire to expand the at-risk integrated model to East and West areas of Tennessee, stakeholders are expressing concern that this might occur prior to an adequate evaluation to determine how effective this model is for persons with SMI.

Evaluation strategies are being developed to respond to three questions:
1) Do persons with SMI have better access to behavioral health care?
2) Do persons with SMI have better access to health care?
3) Do persons experiencing early signs of mental illness or emotional problems have better access to early behavioral health intervention?

Tennessee

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

Legislative Initiatives and Changes

Public Chapter 812: This bill from the 2006 legislative session required the Department, in conjunction with community stakeholders, to recommend options for access to non-emergency behavioral health services for individuals in the state who are uninsured. A report was submitted by DMHDD in November 2006. Subsequent bills related to PC 812 were put forth in the House and Senate. No funding for this purpose was made available; however, efforts continue to determine the best and most cost effective method for service delivery.

Other legislative action with possible impact upon the behavioral health system or its service recipients and stakeholders includes:

Public Chapter 27:Immunizations offered by hospitals to elderly.
Requires hospitals licensed by the Department of Health to, from October 1st through March 1st of each year, offer inpatients 65 and older immunizations for flu and pneumococcal diseases prior to discharge.

Public Chapter 45:Jason Flatt Act of 2007.
Specifies that annual in-service training for teachers and principals include two hours of training in suicide prevention.

Public Chapter 47:Isolation and Restraint.
Specifies that a person with mental illness or serious emotional disturbance may be isolated or restrained only in emergency situations if necessary to assure the physical safety of the person or another person nearby or to prevent significant destruction of property. Requires that a professional authorized by DMHDD rules shall see and evaluate the person's condition within one hour of the intervention.

Public Chapter 200:Attendance of delinquent juveniles.
Modifies requirements for notification of school officials of the attendance of juvenile delinquents. Expands offenses for which such notification is necessary and adds persons to whom notification must be provided. Makes failure to provide notice punishable as a contempt of court. Requires principal to be notified when adjudicated juveniles with a history of specified violent offenses are transferred into their school.

Public Chapter 247. Encourages the Commission of Education to use two teacher in-service days per year to train school personnel on issues of prevention and intervention strategies for students in the areas of behavioral/emotional disorders. Such training shall place an emphasis on understanding the warning signs of early on-set mental illness in children and adolescents and may be conducted by school counseling personnel or mental health clinicians, or by approved personnel from mental health advocacy organizations using curricula approved by the Departments of Education and Mental Health and Developmental Disabilities.

Public Chapter 259:Training requirements for law enforcement officers.
Requires all police officers and highway patrol officers be provided training on proper response to persons with mental illnesses. Also requires the Peace Officer Standards and Training Commission's curriculum to include such training.

Public Chapter 311:Sentencing-alcohol and drug treatment.
Allows a court to sentence an offender to undergo alcohol and drug assessment and/or treatment with cost assessed to person receiving treatment unless person is found indigent. Establishes a $100 fee from each conviction to be deposited in the alcohol and drug addiction treatment fund.

Public Chapter 314.
Requires principal of a juvenile delinquent's school to develop a transition plan for a student returning to school who has been treated involuntarily for a mental health disorder. Maintains that the record shared with the school regarding the student's offense and treatment not be integrated into the child's student record. Treatment centers are required to inform principal if a child leaves a voluntary treatment program and is still believed to pose a likelihood of serious harm.

Public Chapter 356:Mental health patient information release.
Requires that patients receiving mental health services be periodically afforded the opportunity to approve and sign an information release permitting certain disclosures to family members or other designated person at time of admission to inpatient treatment, an emergency room, or crisis response setting. Specifies that the service recipient may withdraw the authority to release any information previously authorized, to release the information to any individual previously authorized or to modify the type of information authorized.

Public Chapter 375:Juvenile courts can operate a drug court treatment program.
Permits juvenile courts to develop and operate drug court treatment programs. Limits who can apply for drug court treatment program grant funds to an existing drug court treatment program created by a court exercising criminal (not juvenile) jurisdiction.

Public Chapter 391:Hospital access to patient medical records.
Declares that the public policy of this state is that hospitals have complete access to health care providers who make entries in hospital patient medical records for information regarding entries made in those records. Also clarifies that there is no implied covenant of confidentiality preventing health care providers from communicating with each other in the course of providing care and treatment to a patient; requires that any information received from a health care provider correcting or modifying a patient's hospital record be made part of that patient's hospital record with a notation as to the date the information was supplied and the name(s) of the person(s) supplying the information.

Public Chapter 402:Discipline of students for fighting.
Authorizes any principal, principal-teacher or assistant principal to suspend or expel for one year two or more students who initiate a physical attack on an individual student on school property, at a school activity, or traveling to or from school.

Public Chapter 429:Mental Health Services Equity.
The commissioner of the department of finance and administration shall report to the senate general welfare, health and human resources committee and the house health and human resources committee no later than January 15, 2008, and annually thereafter, on indicators of equity in the service delivery system.

Public Chapter 468:Abuse or neglect of an impaired adult.
Clarifies that knowingly abusing or neglecting an impaired adult is a Class C felony. Specifies that in order to prosecute and convict a person of such violation, the state does not have to prove that the adult sustained serious bodily harm.

Public Chapter 585:Evidence-based services used for treatment of juveniles.
Prohibits DCS from expending state funds on any juvenile justice program or program related to the prevention, treatment or care of unruly and delinquent juveniles, including any service model or delivery system, unless the program is evidence-based. Requires that implementation of evidence-based programs be accompanied by monitoring and quality control procedures; requires corrective action when standards are not met.

The bills below did not pass in the 2007 legislative session but were referred to a study committee for further review and possible action in 2008.

SB1269/HB1883: Authorizes assisted outpatient treatment as an alternative form of mandatory outpatient mental health treatment. Study is based on a law referred to in many states as Kendra's Law.

SB1653/HB1116: Requires county sheriffs to file written policies granting alcohol and drug treatment organizations access to inmates convicted of alcohol and drug related offenses with the DMHDD.

SB0308/HB2063: Creates the Department of Aging and Disability and transfers to that department the duties of the Commission of Aging and Disability.

Tennessee

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Description of Regional / Sub-state Programs

There are currently twenty-one private, non-profit CMHAs providing the bulk of public behavioral health services in Tennessee, including seventeen Community Mental Health Centers (CMHCs) and four specialty providers. These traditional provider agencies service more than 150,000 adults and children each year at one of more than 250 sites across state.

The majority of these agencies have undergone major restructuring to accommodate on-going changes in TennCare enrollment, service mix, and reimbursement procedures due to revised contracts with MCCs under the TCPP. The nineteen agencies under contract to DMHDD as Mental Health Safety Net (MHSN) Program providers have had to redesign their internal system procedures to efficiently deliver services to those adults with SMI who were disenrolled from TennCare.

The TennCare integrated care pilot program, begun on April 1, 2007, has introduced new challenges for the Middle Tennessee agencies even though the implementation process went well. Evaluation is planned as part of the pilot program to determine the effectiveness of the carve-in model compared to the carve-out approach that has been in place for a decade.
These agencies are also under contract as providers in the network to serve persons enrolled this year in the Cover Tennessee plans that have become available to a number of Tennesseans who have previously been uninsured.

The FY06 reform of the TennCare Program made it more difficult to qualify for TennCare benefits due to changes in the eligibility requirements. As a result, many among the working, lower-income population lost TennCare benefits, which led to increased numbers of uninsured persons at CMHAs for services.

While the majority of CMHAs are fiscally stable and can offer a limited range of services to this population, most cannot subsidize the level of charity care necessary to provide the required services on an intensive or long-term basis. Several agencies are having financial difficulties and are looking at new affiliations and/or corporate mergers as a way to preserve service capability. Recent problems have developed for the first time in some areas of the state due to difficulties recruiting and retaining clinical staff, as competition can offer higher salaries and better employee benefit packages.

In addition to TennCare, most behavioral health agencies receive some other financial support through the United Way, private fund-raising activities, Employee Assistance Program contracts, commercial health insurance plans, and other local, county and state grants. However, the percentage of Medicaid (TennCare) dollars received as revenue by these agencies has become an increasingly larger portion of agency funding due to the loss of various local and commercial revenue sources. In FY06, TennCare revenue increased to approximately 56% of the level of funding for the twenty-one agencies that make up the bulk of the statewide publicly funded behavioral health delivery stem.

Tennessee

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

State Mental Health Agency Leadership

A commissioner heads the State Mental Health Authority. The Commissioner of MHDD is a cabinet-level position and has direct access to the Governor. The Commissioner's Core Team includes the Executive Directors of the Divisions of Administrative Services, Alcohol and Drug Abuse Services, Clinical Leadership, Managed Care, Policy and Legislation, Recovery Services and Planning, and Special Populations and Minority Services. Staff in each of these areas provide leadership in service development and participate in collaborative efforts with a number of other federal, state and community partners. (A Department organization chart is included as Appendix 4.)

The Division of Administrative Services oversees contracting and auditing, information systems, and the budget.

The Division of Alcohol and Drug Abuse Services oversees community programs and activities designed to reduce substance abuse by promoting prevention and reducing high risk behaviors. Division services ensure that treatment services are available for all individuals in need. DADAS and Division of Special Populations staff collaborate on service initiatives for co-occurring populations.

The Division of Clinical Leadership staff, including the Chief Medical Officer and Chief of Pharmacy, seeks to assure high quality services through consultations, clinical oversight, education, the development of best practice guidelines and research reviews.

The Division of Managed Care provides oversight, monitoring, and evaluation of the MCCs that contract to provide services for the TCPP. DMC works closely with the Bureau of TennCare on priority population definition and classification, contract language, enrollment criteria, marketing and educational material development, best practices, data collection and reporting, and adequacy of provider networks.

The Division of Policy and Legislation (DPL) works with all program and planning areas to develop departmental policy through legislative initiatives, grant applications, data collection, contracting, program monitoring and service recipient advocacy. DPL oversees adult and juvenile outpatient and inpatient forensic evaluations and training and the Criminal Justice/Mental Health Liaison Project, working collaboratively with community providers, jails, law enforcement, judges and court officers.

DPL also has administrative oversight of the Office of Consumer Affairs, which plays a crucial role for service recipients and consumers through its Ombudsman program, TennCare appeals assistance, complaint resolution, information and referral, and education and advocacy efforts.

The Division of Recovery Services and Planning (DRSP) oversees the SETH initiative (Support, Education, Transportation, Housing), promoting recovery for persons diagnosed with SMI and COD. Staff provide collaborative leadership with Vocational Rehabilitation, employers, local builders, banks, federal loan corporations, community homeless coalitions, consumer and family support and advocacy organizations and state and local transportation agencies, public and private. DRSP staff also coordinate Departmental planning activities including state and regional planning and policy councils, the Three Year Plan, the Mental Health Block Grant Plan, and the Finance and Administration Strategic Plan. DRSP staff also oversee the MHSN program.

The Division of Special Populations and Minority Services develops and monitors a continuum of services across the lifespan, focusing on services for children and youth with or at risk for SED, those with COD, and older adult populations. Division staff also coordinate Title VI activities and work closely with the faith-based community to develop outreach strategies for individuals and families reluctant to access traditional mental health providers. The Executive Director of this Division also serves as Chief Nurse for the Department.

DMHDD contracts for MHSN services and manages a database of TennCare disenrollees eligible for services, confirming termination from TennCare and overseeing registration. Staff provide claims auditing of the contracted providers and prepare reports related to registration and audit findings. DMHDD staff prepare routine stakeholder updates of MHSN registrations and services provided and a report for providers to enable targeted outreach to disenrollees residing in their service areas.

Department staff provide advocacy, planning, service development, program monitoring and evaluation, budget monitoring, and technical assistance for non-TennCare community support programs, forensic services and grant projects. The Department oversees a number of federal grants that support initiatives in data information systems, homelessness, housing, substance abuse, systems of care and suicide prevention.

DMHDD maintains mental health licensing responsibilities, oversight of the forensic services contract for adults and juveniles and PASRR (Preadmission Screening and Resident Review) activities for those persons applying for nursing home admission and thought to have a mental illness or a developmental disability other than mental retardation.

The Office of Hospital Services oversees hospital staffing requirements, quality assurance, and community relations for the five state RMHIs. In addition, DMHDD is responsible for investigations at RMHIs and complaint resolution for consumers, family members, legislators, and the public.

The Department identifies, advocates, and plans for adults with SMI and children and youth with SED. DMHDD administrative and other key staff work closely with other service departments to assure the integration of multi-agency funded services to provide appropriate service components that are designed to meet behavioral health needs along a continuum from education and prevention to resiliency and recovery.

Tennessee

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Included in Overview Section of Adult Plan

Tennessee

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Included in Summary of Areas... Section of Adult Plan.

Tennessee

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

Included in New Developments and Issues Section of Adult Plan

Tennessee

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

Included in Legislative Initiatives Section of Adult Plan

Tennessee

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Included in Description of Regional Resources Section of Adult Plan

Tennessee

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Included in SMHA Leadership Section of Adult Plan

Tennessee

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

a) ADULT MENTAL HEALTH SYSTEM

Criterion 1: Comprehensive Community-Based Mental Health Service System

Approximately 122,072 adults received publicly funded behavioral health services through the TCPP and the MHSN Programs in FY06; a 12.7% decrease from FY05 in total numbers served. (URS Table 2A) This decrease is due to a reduction in eligibility for the TennCare (Medicaid) waiver program, resulting in nearly 170,000 adults losing public health care coverage during the fiscal year. As of July 2007, approximately 12% of disenrolled adults were assessed as SMI and were registered for MHSN services, a 3% increase from FY06.

In FY06, the percent of persons responding positively regarding access dropped from 94% to 87% in the adult consumer survey. This may reflect some diminished service capacity or be a reflection of greater numbers surveyed – there was a 70% increase in the number of total survey responses received over the previous year. It is noted that the addition of an "I am neutral" survey response in the FY06 survey resulted in a general decrease in overall survey scoring. (URS Table 11a)

There was an overall decrease in the number of adults served in all race and ethnicity categories reported. (There continue to be no services reported in the Native Hawaiian/Pacific Islander category.) The ratio of the number of adults in Asian and Hispanic categories receiving services, as a percent of the total number served, has slightly but steadily increased over the past three years. There were no significant changes from previous years in service access by age and sex status.

There was an overall decrease of 50% in the total number of TennCare adult inpatient psychiatric admissions from FY05 to FY06. TennCare admissions to state psychiatric hospitals dropped from 35% of all admissions to 22%. (URS Table 3) These figures reflect not only the decreased TennCare waiver population, but the continued focus on alternative community services by MCCs.

During FY06, Block Grant and other non-TennCare state and federal funding served more than 35,500 adult consumers and their families directly, with hundreds of other non-service recipient adults benefiting from education and training activities.

Criterion 2: Mental Health System Data Epidemiology

Tennessee uses the federal estimate of 5.4% of the over 18 population as an annual prevalence rate for adults with SMI; using 2005 figures supplied by the NASMHPD Research Institute (NRI), this results in an estimate of 242,589 adults. Some 196,858 adults were identified as SMI and enrolled in TennCare for some period of time during FY06. The proportion of the prevalence rate served through the public mental health system has climbed steadily since 1998, but is expected to decline due to continued TennCare disenrollment and opportunities for alternate health care coverage options becoming available through the Cover Tennessee initiatives.

Throughout FY06, the number of priority adult TennCare enrollees steadily decreased in each of the seven mental health planning regions of the state, reflecting TennCare disenrollment. However, as of April 30, 2007, adults with SMI comprised 10.6% of enrollment, and that percentage has never fallen below 10% throughout TennCare's history.

Of the number of adults receiving publicly funded services in FY06 (122,072), 73% were assessed as SMI (89,113); an increase from 65% in FY05. (URS Tables 2A and 14A)

Criterion 3: Children's Services – Not Applicable to Adult Plan

Criterion 4: Targeted Services to Rural, Homeless, and Older Adult Populations

Approximately 30% of adult TennCare enrollees assessed as SMI reside in a rural county; a constant percentage over the past three years. During that time, rural enrollees consistently accounted for 29% to 30% of total persons served. DMHDD conducts monthly audits to monitor the adequacy of behavioral health provider networks to determine if access to services meets contractual standards. Telemedicine projects allow for improved access to assessment, treatment and specialist consultation in targeted rural areas of the state.

For FY06, the state reported living situation, including homeless status, only for those adults completing the annual consumer survey. (URS Table 15) Approximately 2.5% of 8,009 adult responders indicated "Homeless/Shelter" for living situation; an additional 3% marked "Other", which might include non-shelter homelessness. Point-in-time counts of the homeless in Tennessee in 2007 indicated some 10,300 persons living unsheltered or sheltered, an estimated 44% with mental illness. DMHDD is dependent upon federal support from the Projects for Assistance in Transition from Homelessness (PATH) to provide outreach, referral and case management services to homeless adults. PATH and state supplemental funding provides ten projects, five of them serving smaller cities and rural counties.

Adults over the age of 65 comprise 12.4% of Tennessee's population. Approximately 14% of adult TennCare enrollees are age 65 or older, with 5% receiving a behavioral health service in FY06. Of the 4,248 adults age 65 or older receiving a TennCare or MHSN public behavioral health service, 76% were assessed as SMI. DMHDD supports four outreach-to-older-adults projects and oversees a CSAT grant for services for adults age 55 and over with mental health and alcohol abuse in the Nashville area.

Criterion 5: Management Systems

DMHDD employees approximately 2,850 employees; 2,680 at the five RMHIs. DMHDD non-institute staff levels continue to remain stable. State psychiatric institutes consistently deal with challenges in recruitment and retention of qualified nursing staff, psychiatrists, and pharmacists. The Department of Human Resources completed policy changes that allow for greater flexibility for negotiating starting salaries for these staff classifications. Although challenges remain, resources are adequate to meet the needs of those served and maintain full accreditation.

DMHDD continues to provide for training events for emergency personnel and first responders and partners with the DOH in all-hazards behavioral response as part of bioterrorism, mass casualty and pandemic response planning. The DMHDD, MCOs and MCCs provide a variety of training events for community providers.

Strengths and Weaknesses of the System

Strengths of the current system of care for adults include the wide availability of consumer-run education, support and recovery services; the successful interface between criminal justice and mental health; a collaborative and highly successful housing initiative; administration and staff dedication to transformation goals and a recovery-oriented system; and effective consumer, family and advocacy involvement from local to state levels.

The TennCare benefit package includes psychosocial rehabilitation and crisis services. Some MCCs provide financial support vouchers for supervised housing and are involved in the development of both recovery-focused services and philosophy. Services included in the MHSN program appear to be adequately serving individuals who lost TennCare coverage. Additionally, Tennessee's administration is committed to providing basic health insurance opportunities to all citizens. While new funding was not available this year, continued funding for those adults disenrolled from the TennCare waiver population is a first step in providing options for basic behavioral health care for everyone.

An analysis of service system data for FY06 indicates the following gains:

- ✓ an increase in the number of MHSN registrations;
- ✓ reasonably positive consumer response to service access;
- ✓ maintenance of service levels of adults with SMI;
- ✓ decreased inpatient utilization; and
- ✓ specialized outreach to older adults.

Challenges include evaluation of both carve-in and carve-out managed care system outcomes in order to promote best practices and integrated care; determining the impact of the implementation of Cover Tennessee; assuring widespread adoption of a recovery orientation at all levels of state and local service agencies, and advocating for increased funding to stabilize and grow the provider base and to expand prioritized services.

FY06 service system data also indicate the following needs:

- ✓ continued outreach to disenrolled adults eligible for MHSN services;
- ✓ increased outreach to underserved older adult populations; and
- ✓ continued efforts in recruitment and retention of DMHDD staff and community providers.

Tennessee

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Unmet Service Needs

Service and support needs are identified through an annual needs assessment process with input from all regional and state councils and DMHDD division staff. This process allows for a broad grassroots forum to advise the Department on the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families and provides citizen participation in the development of the DMHDD annual budget improvement request.

Title 33 of the Tennessee Code Annotated, the mental health and developmental disability law, requires the DMHDD to develop a Three Year Plan based on the annual needs assessment and Council recommendations. Requests are reviewed and recommended for inclusion into the Three Year Plan by the Planning and Budget Committee of the MHDD Planning and Policy Council. The Department's improvement budget request is tied to the annual update of the plan.

During FY07, the following needs were most identified for adult services through the above process: 1) expansion of crisis stabilization services into each region of the state, 2) financial support for indigent medications, 3) integration of services to include co-occurrence services and medical services, 4) additional funding for existing services to increase access, 6) increased employment opportunities, and 7) additional licensed professionals in all mental health care fields, especially in rural areas.

Tennessee

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

Plans to Address Unmet Service Needs

DMHDD submitted FY08 budget improvements in the amount of $15,000,000. Funding was requested for the community service initiatives for adults listed below.
o Expansion of criminal justice/mental health liaison project into six additional counties.
o Expansion of the piloted Creating Jobs Initiative, an employment project to create job opportunities for persons with mental illness and co-occurring disorders.
o A recovery initiative for improving self-sufficiency for persons with mental illness by employing a consumer in each of the three grand regions of the state to work with local community agencies to address stigma and educate consumers about housing and employment opportunities.
o A pilot program for Shelby County (Memphis) to implement interventions to improve acceptability, accessibility and utilization of services in the African American community.

Budget improvement dollars were granted in the amount of $2,000,000 for lease payments and improvements related to the RMHIs. A 2.5% across-the-board cost of living increase for community services was not funded.

While not included in the Governor’s approved budget for DMHDD, advocacy efforts resulted in minor additional funding through Appropriations Legislation for non-recurring dollars for the Shelby County pilot ($250,000) and for a public awareness and education campaign sponsored by the Tennessee Mental Health Association ($100,000).

The Commissioner of MHDD has discussed ideas for the Shelby County pilot with local stakeholders and a proposal will be submitted. It is currently earmarked for interface of primary and behavioral health care. DMHDD is hoping to partner with the Mental Health Association to target public awareness activities to the age 18-24 demographic, which is a target population for SAMHSA anti-stigma activity.

Despite the lack of financial support, plans are moving ahead in some areas. The Creating Jobs Initiative continued through the use of VISTA volunteers and collaboration with regional housing facilitators through July 1, 2007; the DMHDD Office of Consumer Affairs has completed a certification track for Peer Specialists, and WRAP facilitators are being trained statewide.

The majority of new state dollars were targeted to education. Council and community stakeholders voiced their disappointment to the Governor regarding the lack of improvement dollars for several years and the low priority mental health services appears to hold in the budget priorities process.

The Three-Year Plan also contains strategies related to identified needs in the areas of crisis stabilization, integration of services and workforce development.

Tennessee

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Summary of Significant Achievements Reflecting Progress Toward the Development of a Comprehensive Community-based Mental Health System of Care

Achievements in FY07 that reflect development of a more comprehensive community-based mental health system of care for adults include:

o The MHSN program continues with increased numbers of persons registered and services delivered.

o A MCC/DMHDD co-sponsored Recovery and Resiliency stakeholder conference launched a statewide, shared commitment to transform the public mental health system to promote and support recovery and resiliency for all persons with mental illness or emotional disturbance.

o Additional crisis stabilization services were made available in three areas of Middle Tennessee.

o Approximately 370,000 citizens in the Middle Tennessee area were successfully transitioned to a fully integrated managed care program.

o The Office of Consumer Affairs has completed its review for certification of the first group of peer specialists in Tennessee. Fourteen individuals have been approved and certified and other applications are being processed by the committee.

o Housing options continue to grow through the Creating Homes Initiative (5,729 new or improved units of housing and $152,301,801 in leveraged funding).

o A Mental Health Court was developed in Washington County in Upper East Tennessee. This is the second Mental Health Court in the state and was a collaborative effort between regional Criminal Justice/Mental Health Liaison staff, local law enforcement, and the judicial system. No state or federal funding currently supports this effort.

o A CSAT grant was awarded to implement the Matrix Model of intensive outpatient treatment for methamphetamine addicted adults. Six rural counties were chosen due to the high number of meth lab busts reported by law enforcement. Individuals requiring mental health assessment and/or services are seen within the program.

o TN-MAP, the Tennessee Medications Algorithm Project, continues at one RMHI. While local CMHAs are interested in maintaining continuity beyond the hospital setting, barriers exist to full outpatient participation. Division of Clinical Leadership staff are meeting with CMHAs to troubleshoot existing impediments to full implementation of the model. CMHAs in East TN have expressed interest in replicating the project in their area.

Complete documentation of FY07 achievements will be contained in the 2007 Implementation Report due for submission on December 1, 2007.

Tennessee

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Brief Description of the Public Mental Health System Envisioned for the Future

DMHDD envisions a public behavioral health system with prevention, early intervention, community care, recovery and resiliency as organizing principles. We envision the best possible outcomes for those we serve with continued goals of decreased stigma, increased use of evidenced based practices, and a continuum of consumer driven recovery services.

Three major variables have and will continue to impact the future public mental health system in Tennessee. The most significant of these currently are:

- The trend in decreasing funds, both state and federal, available to support and expand the public behavioral health services system.
- Outcomes of the carve-in managed care treatment model in Middle Tennessee.
- The impact of a restricted criteria for TennCare eligibility on DMHDD's ability to sustain adequate funding to serve an increasing number of persons through 'state only' and 'judicial' categories.

The Five-Year Strategic Plan for Tennessee's Executive Branch contains the following goals for DMHDD.

1. By FY 2011, MHDD will increase the public's knowledge and understanding of mental illness and its effective treatments by providing activities to reduce stigma to 2,000 individuals.

2. By FY 2011, MHDD will increase mental health service providers' understanding of the prevalence of and best practice treatments for co-occurring disorders by providing training on best practices to twenty-two community mental health agencies.

3. By FY 2011, MHDD will enhance funding sources for a continuum of recovery and resilience services to better meet the needs of Tennesseans with mental illness by maintaining a minimum of eight active grant awards from non-state sources.

4. By FY 2011, MHDD will increase the number of consistent practices used in the five Regional Mental Health Institutes (RMHIs) to twenty-three.

5. By FY 2011, MHDD will provide fifty-four clinical rotations or internship experiences as a recruitment tool to promote public sector careers for mental health professionals.

Although much has been done, DMHDD leadership believes that much more can be accomplished to provide a viable mental health and substance abuse benefit in employer-based insurance; to integrate mental health, substance abuse and primary health care services; and to enhance implementation of prevention programs for substance abuse and early intervention programs for individuals exhibiting first signs of a mental illness.

DMHDD has been and will remain integral to the planning, implementation and monitoring of significant events in the continuing evolution of our behavioral health care system.

Tennessee

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

b) CHILDREN'S MENTAL HEALTH SYSTEM

Criterion 1: Comprehensive Community-Based Mental Health Service System

Approximately 48,526 children and youth below the age of eighteen received behavioral health services through the TCPP in FY06, a 3% decrease from FY05. (URS Table 2A) In FY06, 85% of returned Youth Services for Families surveys reported positively on access, an decrease from 91% in FY05. It is noted that the number of persons responding to the FY06 survey increased by 81% over FY05. The addition of a choice of "I am neutral" is also thought to have influenced score averages. (URS Table 11a)

In FY06, there were slight decreases in most race categories, corresponding to an overall decrease in total numbers served. Notably, there was a 6% increase in the number of children served who identified as Hispanic.

Age breakout of service recipients remains generally the same: 54% between the ages of 0 and 12 and 46% between the ages of 13 and 17. Sixty percent (60%) of those served were male.

Between FY05 and FY06, there was a 15% decrease in the number of children and youth below the age of 18 served in state psychiatric hospitals and a 6% decrease for other psychiatric hospitals. (URS Table 3) The statewide specialized crisis services program for children, developed in FY05, continues to positively impact inpatient rates via a focus on effective diversion through in-home intervention and the use of alternative community resources.

Approximately 265,100 additional children and youth, caregivers, teachers and other adults were served through DMHDD community contracts; nearly 95% of those by programs offered within school systems. Fifty percent (50%) of contracted programs receive Block Grant funding.

Criterion 2: Mental Health System Data Epidemiology

Using the highest range number for Tennessee in the annual prevalence tables provided by NRI, there are 92,330 children and youth estimated to have SED. Approximately 62% of that number were enrolled in the TennCare Program as SED for some time during FY06, with 30% of those enrollees receiving services. Although TennCare enrollment of persons under age 18 has increased, the number of children and youth accessing the public mental health system has decreased steadily since FY04. However, 58% of the total number of persons under age 18 receiving services in FY06 were children and youth assessed as SED, an increase from 52% in FY04 and 57% in FY05. (URS Tables 2A and 14A)

Children and youth with SED comprise nearly 4% of current enrollment, and that percentage has remained generally stable throughout TennCare's history.

Criterion 3: Children's Services

Given a holistic philosophy and the various entities that provide services to children, it is advisable to pay careful attention to integration of effort. The Governor's Children's Cabinet was established in 2003 to coordinate and streamline services to children.

The Commissioner of each child-serving department, representatives of child advocacy organizations, and citizens with a strong commitment to and understanding of the challenges and issues affecting Tennessee's children serve as members.

The Governor's Office of Child Care Coordination ensures that the delivery of services to children is effective, efficient and coordinated. This group reviews problematic cases involving multiple agency providers and identifies gaps in service coordination that impede success. Findings may then be forwarded to the Children's Cabinet for Commissioner review and policy revision as needed.

TennCare policy is targeted to broaden eligibility to all children of low-income families without access to insurance coverage. The CoverKids portion of the Cover Tennessee program aims to assure health care coverage to every child in the state.

Transitional services, always a stakeholder concern, are being brought to the forefront of concerns through regional and state task forces. Tennessee is fortunate to be able to target its state and Block Grant dollars to provide a variety of early identification, intervention, prevention, and family support services not always seen in other states.

Criterion 4: Targeted Services to Rural and Homeless Populations

As of April 2007 enrollment data, 23% of children with SED enrolled in TennCare reside in a rural county. This percentage is down from 25% last year. Of the total number of children and youth with SED receiving services during FY06, 24.6% were rural county enrollees.

The state is currently able to report living situation, including homeless status, only for those caregivers completing the annual consumer survey. (URS Table 15) In FY06, only 2% of responders indicated "Homeless/Shelter" or "Other" for living situation. Estimates of the number of homeless families with children ranges from 4,000 to 4,500. School system data shows a gradual increase each year of homeless children attending school.

Children in homeless families are considered at high-risk for emotional disturbances. Six outreach programs for homeless families with children provide case management services and refer homeless families and their children to appropriate services. Some 1,430 homeless families were referred to the Homeless Outreach Program for services in FY06. This program is one of the few of its kind for children who are living in homeless conditions and it is making a measurable impact on this population. Approximately 22% of children receiving project services were assessed as SED.

Criterion 5: Management Systems

Specific to services for children, there is continuing need for increased clinical staff with specialization in this area, especially outside of the metropolitan areas. MCC funding was previously provided to expand clinical staff for children's services at various agency locations across the state. Telemedicine is also assisting in this effort, providing initial assessments and specialist consultations.

Training events for first responders and other mental health staff in specific courses in trauma interventions with children, school-based intervention planning and response, and family-based intervention is drawing a larger and more diversified number of participants.

Strengths and Weaknesses of the System

Strengths of the current system of care for children and youth include: targeted prevention and early intervention activities for pre-school and school-age children; expansion of systems of care; pockets of integrated services; statewide planned respite services; outreach to homeless families with children; anti-stigma educational efforts for students, teachers and parents; and service programs for targeted special populations.

DMHDD also supports a school-based suicide awareness and prevention program for middle and high school students and has begun a federal grant program to reduce suicides and suicide attempts in high-risk youth ages 10-24.

In addition, it is noted that TennCare coverage to children and youth under age 18 was not included in disenrollment and benefit reductions; assuring health care coverage for children continues to be a priority.

An analysis of service system data for FY06 indicates the following gains:

- ✓ increased services to Hispanic children and youth;
- ✓ reasonably positive family response to service access;
- ✓ a high number of persons impacted through state and block grant funded services;
- ✓ adequate service rates to rural children and youth;
- ✓ effective intervention for children who are homeless; and
- ✓ decreased inpatient utilization.

Challenges continue in developing a broadly integrated service system, increasing access to child care specialists, increasing the availability of in-home service options, expanding school-based services, and developing a full continuum of transitional services for youth age 16-21.

FY06 service system data also indicate the following needs:

- ✓ the development of strategies to increase the number of TennCare enrolled children and youth accessing services;
- ✓ education and training in behavioral health assessment and referral procedures for primary care physicians and pediatricians; and
- ✓ a strategy to increase the number of qualified child specialist mental health workers in the state.

Tennessee

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

C&Y - Unmet Service Needs

Title 33 of the Tennessee Code Annotated, the mental health and developmental disability law, requires the DMHDD to develop a Three Year Plan based on the DMHDD Planning and Policy Council recommendations. The plan must be updated at least annually, based on an assessment of the public need for mental health and developmental disability services and supports. The Department's improvement budget request is tied to the annual update of the plan.

Service needs are identified through an annual needs assessment process with input from all regional and state councils and DMHDD division staff. They are then reviewed and prioritized as recommendations for inclusion into the Three Year Plan by the Planning and Budget Committee of the MHDD Planning and Policy Council. This process allows for a broad grassroots forum to advise the Department on the desirable array of prevention, early intervention, treatment, and habilitation services and supports for service recipients and their families and provides citizen participation in the development of the DMHDD annual budget improvement request.

During FY07, the following needs were most identified for children and youth through the above process: 1) integration of services to include co-occurrence services and medical services; 2) additional funding for existing services to increase access; 3) workforce expansion in the areas of child specialists, including physicians, nurses and social workers; 4) services for transitional youth, including an educational component similar to BRIDGES; 5) expanding BASIC into more schools; 6) increased residential treatment capacity; and 7) intensive outpatient programs for children and youth with co-occurring disorders.

Tennessee

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Plans to Address Unmet Service Needs

DMHDD submitted its FY08 budget improvement in the amount of $15,000,000. Included in the improvement request was funding for the expansion of early intervention initiatives through increased capacity for BASIC, RIP, and school-based mental health liaison services. A 2.5% across-the-board cost of living increase for community services was also included.

Budget improvement dollars were granted in the amount of $2,000,000 for lease payments and improvements related to the RMHIs.

While not included in the Governor's budget for DMHDD, advocacy efforts resulted in minor additional funding through Appropriations Legislation for non-recurring dollars for a Youth Suicide Prevention Program ($250,000). This funding was added to the Department of Health budget allocation; no decision of how funding will be used has been finalized.

DMHDD carve-in contracts for the delivery of health and mental health care to TennCare enrollees in Middle TN encourages behavioral health screening in primary care for all enrollees and mandates behavioral health screening for enrollees in physical disease management programs.

New Freedom Commission goals form the framework of the Three Year Plan. Strategies for FY08 in the FY2008-2010 Three Year Plan related to unmet service needs identified by staff and stakeholders for children and youth include:

Strategy 3.2.8: To collaborate with other state agencies to assess and resolve issues in the delivery of services to children and youth with mental illness and serious emotional disturbance.

Strategy 3.2.10: To collaborate and partner with other state and local agencies to assess and evaluate procedures needed to enhance the transition of adolescents to adult mental health services.

Strategy 3.2.31: To seek funding options to expand school-based mental health services.

Strategy 4.1.3: To provide prevention and early intervention services for at-risk children including, but not limited to, suicide prevention.

Strategy 4.1.5: To expand BASIC, a prevention and early intervention program for K-3 elementary school children.

The current Three Year Plan is available for review on the DMHDD website at http://www.state.tn.us/mental/overview/html – link on left banner.

Tennessee

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Summary of Significant Achievements Reflecting Progress Towards the Development of a Comprehensive Community-based Mental Health System of Care

The number of children and youth TennCare enrollees served during FY06 decreased by nearly 4% from FY05; however, of the total number served, the proportion that were children and youth with SED increased by 1%.

Achievements in FY07 that reflect development of a more comprehensive system of care for children and youth include:

o Contracted with the University of Memphis, Early Intervention Section, to run a RIP (Regional Intervention Program) Expansion. There has been no Memphis RIP since June 2004.

o Implemented the Tennessee Lives Count (TLC) grant contract targeted to high-risk youth ages 10-24. A Youth Coordinator and two Youth Trainers will provide training about suicide risk and intervention strategies at conferences and other training forums and assist in the development and distribution of suicide prevention marketing materials.

o Maintained interdepartmental funding from DOE for two school-based mental health liaison positions in Nashville, Davidson County.

A complete narrative of FY07 achievements will be included in the 2007 Implementation Report due December 1, 2007.

Tennessee

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Brief Description of the Public Mental Health System Envisioned for the Future

The overall goal for children's services is expanding the system of care approach throughout the state. Systems of care promote coordinated service planning at all levels of family, school, and community interaction and demonstrate positive outcomes in the areas of out of home placement, family stability, school attendance and performance, and social relations. The continuation of the systems of care delivery model for children and youth in state custody is a significant accomplishment.

It is estimated that 125,000 children in Tennessee do not have health insurance coverage. CoverKids, a part of the Cover Tennessee initiative, provides health insurance coverage, including behavioral health benefits, to uninsured children in the state. Eligibility is capped at 250% of the federal poverty level, but those with higher incomes may be able to buy in to the program.

Senate Joint Resolution 799 (SJR799), passed by the Tennessee State Legislature during the last term of the 104th General Assembly in 2006, directed the Select Committee on Children and Youth to establish a study committee to develop an interim report describing the mental health needs of children and youth and an initial blueprint for a comprehensive system and a full plan for development, implementation, and oversight of such a system.

The sub-committee developed three initial strategies toward designing a comprehensive, coordinated, family-centered and culturally responsive system for behavioral health care: 1) sub-committee hearings, 2) a series of town hall meetings, and 3) survey administration. Three hearings have been convened. Six community town hall meetings took place in FY07 with four more scheduled before the end of September. Town hall meetings invite participation and comment from parents, teachers, providers, and other stakeholders regarding the service needs of children and experiences with the system. Survey response has been solicited from youth, parents, mental health providers, practitioners and administrators, primary care providers, juvenile court judges or staff, child advocates, DCS case managers, and any other interested persons. Over 500 survey responses have been collected to date.

In addition, four workgroups are planned. The Service Array Workgroup is the initial workgroup. After the Service Array Workgroup develops a broad picture of the service array structure, workgroups for the following areas will become active: Accountability, Interagency Collaboration, Funding, and Information Management. DMHDD has been actively involved in all three strategies and will participate in the oversight committee for the SJR799 workgroups.

In the April 1, 2007 interim report, the sub-committee states: "It should be considered conclusive from the collective body of information that has come together through activities of Year 1 of the SJR799 study process that there is serious interest and momentum around children's mental health reform."

The three strategies listed above will continue through September. Final committee recommendations for the creation of a unique model system for children's mental health care in Tennessee are to be included in a report to policymakers on or before April 1, 2008.

Tennessee

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Adult - Establishment of a System of Care

Within the Tennessee Code Annotated, Title 33, Chapter 2, Part 1, DMHDD authority and responsibilities are defined as below:

Community Service System
The department shall plan, coordinate, administer, monitor, and evaluate state and federally funded services and supports as a community-based system within the total system of services and supports for persons with mental illness, serious emotional disturbance, developmental disabilities, or at risk for such conditions and for their families. All functions shall be carried out in consultation and collaboration with current or former service recipients, their families, guardians or conservators, service recipient advocates, service providers, agencies, and other affected persons and organizations.

(a) Within the limits of available resources, it is the goal of the state to develop and maintain a system of care that provides a comprehensive array of quality prevention, early intervention, treatment, habilitation and rehabilitation services and supports which are geographically available, equitably and efficiently allocated statewide, allowing people to be in their own communities in settings, based on the needs and choices of individuals and families served.

(b) The state’s purposes are to:

(1) Establish and sustain a broad range and scope of flexible services and supports across the domains of residential living, working, learning, community participation, and family support including crisis, respite and other emergency services, which help service recipients maintain respected and active positions in the community, and

(2) Promote the early identification of children with mental illness, serious emotional disturbance, developmental disabilities, and developmental delay to assure that they receive services and supports appropriate to their developmental level and changing needs.

(c) The general assembly finds as facts that the needs of persons with mental illness, serious emotional disturbance, and developmental disabilities cannot be met by the department in isolation and that such persons need to receive services and supports that are integrated, have linkages between and among other human service agencies and programs, and have mechanisms for planning, developing, coordinating, and monitoring services and supports to meet their needs.

Tennessee

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

1) Current Activities – Adult Plan – Available Services

i. Criterion 1 A Comprehensive Community-Based System of Care

Managed Behavioral Health Care Services: Currently, the TennCare Partners benefits package includes the following service categories for all TennCare enrollees.

- Inpatient/Outpatient Psychiatric Treatment
- Inpatient, Residential, and Outpatient Substance Abuse Treatment Services (except Methadone)
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Psychiatric Rehabilitation Services
- 24/7 Crisis Response Services and Crisis Respite

Mental Health Safety Net Services: Available to adults assessed as SMI disenrolled from the TennCare waiver population.

- Assessment, Evaluation, Diagnostic, and Therapeutic Interventions
- Case Management
- Psychiatric Medication Management
- Laboratory Services Related to Medication Management
- Pharmacy Assistance and Coordination

In addition to the above behavioral health benefit packages, the following services are available within the comprehensive array of community services:

Health – Public Health

DMHDD staff and community providers participate in statewide depression screening activities at state and local events. Supported Living Facilities must provide or procure for each service recipient an annual physical examination, which includes routine screening and special studies as determined by the examining physician. Individuals hospitalized under involuntary emergency status receive physical examination within twenty-four (24) hours of admission.

The Department of Health provides protective flu and pneumonia vaccines for residents of all nursing homes, assisted living facilities, and homes for the aged and disabled. State psychiatric facilities also provide protective vaccines for elderly and frail patients. Local health departments provide a variety of medical screening services free of charge to eligible individuals.

In response to TennCare reform, the State's overall safety net service package included funding for public health clinics to expand the provision of medical services to individuals without health care insurance. In addition, Cover Tennessee initiatives are providing working and low-income citizens with basic health care coverage and medications assistance.

Employment Services: Vocational programs are available at eighteen Psychosocial Rehabilitation Service programs across the state. Services may include, but are not limited to: supported employment, pre-vocational work units, work assessments, job readiness training, and work enclaves. Employment services are also available directly from the Department of Human Services, Division of Vocational Rehabilitation (VR).

DMHDD's employment services staff worked closely with VR to streamline processes for service access. A Crosswalk project has been very successful, resulting in the turn-around time for a priority category determination for adults with SMI decreasing from two months to ten days. The renewed collaboration has also resulted in the designation of VR staff dedicated to assisting those with SMI.

The Creating Jobs Initiative, while not fully funded, is working through regional task groups to develop employment opportunities for persons with mental illness. Train-the-trainer technical assistance has been provided to community agencies in supported employment.

Rehabilitation Services: For individuals not able to or not desiring to work, psychosocial programs and Peer Support Centers provide skill building, promote independent living capabilities, offer peer counseling and provide educational and social rehabilitation opportunities. BRIDGES education and the WRAP process promote consumer empowerment in movement toward recovery and resiliency.

Housing Services: DMHDD supports forty agency-operated HUD group homes and supported living apartments, six assisted living sites, and provides supplemental funding for utilities and rent to assist consumers with SMI to maintain housing of their choice. Tennessee's Creating Homes Initiative has developed more than 5,700 housing options and assists adults with SMI in finding appropriate housing based on their needs and desires.

Educational Services: GED classes and other educational activities are available at Psychosocial Rehabilitation programs and at many of the Peer Support Centers across the state. Adults, aged 18-22, who are still attending school may also be served under the Individuals with Disability Education Act by the Department of Education. DMHDD has been researching funding options to provide supported education services but, to date, funding has not been made available.

Medical and Dental Services: Primary care physician and specialist medical services are provided under TennCare and by various community health clinics, emergency clinics, and hospitals. Community agencies work with local medical and dental providers to secure necessary services for their clients. A portion of independent living assistance funds are available to community providers to access needed medical and/or dental care for priority population adults.

Substance Abuse Services: Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of the MCCs and the DMHDD DADAS through the Substance Abuse Services Block Grant. Contract agencies include CMHAs and other primary substance abuse providers. The Access to Recovery Program, a three-year federal grant, provides service vouchers to expand access to substance abuse treatment through a variety of local providers.

Case Management Services: Mental Health Case Management Services are a benefit of the TCPP. Case managers serve as the agent for linking, facilitating, and monitoring the receipt of direct services and supports. An assessment process provides for measurements of intensity and duration needed and proposed objectives to be met in the service plan. The MCCs have documented policies regarding caseload capacities and expected consumer outcomes. Approximately 50% of priority populations receiving TennCare services are enrolled in case management.

Services for Co-Occurring Disorders: The Co-occurrence Project, a joint effort of the DMHDD Divisions of Special Populations and Alcohol and Drug Abuse Services, supports ten projects across the state for individuals with co-occurring disorder without insurance or ability to pay for services. Case management staff, with experience and specialized training in mental health and substance abuse services, provide services that address clinical, housing, social and other needs that are affected by co-occurring disorders. Services are provided through integrated assessment and treatment. Case managers also provide linkage to other service providers, COD psycho-educational classes, and follow-up services.

DMHDD is also a recipient of a federal grant to coordinate substance abuse services for individuals abusing methamphetamine in Southeast Tennessee and one for services to older adults with substance abuse. Alcohol and drug abuse education modules have been added to the BRIDGES curriculum.

Services for Special Populations: DMHDD supports the following service initiatives for those with special needs:

- Program of Assertive Community Treatment (PACT): Teams are provided under the managed care program and are located in Knoxville and Nashville. This high level-of-intensity service provides integrated services and planning for adults with a history of multiple hospitalizations and/or multiple disorders.

- Older Adults: DMHDD supports four projects offering outreach professional mental health counseling and other support services to adults age fifty-five and over who are homebound or do not access traditional outpatient mental health services. In addition, a three-year CMHS grant supports the initiation of statewide mental health aging coalitions. A three-year CSAT grant is also developing a culturally competent, flexible and comprehensive continuum of care for adults aged 55+ who have mental health needs and are abusing alcohol or other drugs in the Greater Nashville Area.

- Consumers Interfacing with Criminal Justice System: Criminal Justice liaison staff provide early identification of persons with SMI or COD within the criminal justice system, promote diversion alternatives to community programs, and provide training and education to enhance collaborative efforts between the criminal justice and mental health systems. Currently, there are eighteen criminal justice projects covering twenty-three counties. Two Mental Health Courts operate within the state.

- Persons who are Deaf and Hard of Hearing: This population is included in cultural competence efforts, and DMHDD staff participate in meetings of the Tennessee Council for the Deaf and Hard of Hearing. All DMHDD and Council meeting announcements contain special accommodations information and interpreters are provided as needed.

Support Services: DMHDD assists in funding the following support services:

- NAMI-TN: Forty affiliates provide support services for family members and caregivers of persons with psychiatric disorders, including the development of "With Hope in Mind" educational classes and "In Our Own Voice" presentations.

- TN Mental Health Consumers Association (TMHCA): The Association supports training in seven program areas: Wellness Recovery Action Plan, Illness Management and Recovery, Supported Employment, Peer Counseling Training, BRIDGES courses and support groups, and the Regional Advocacy Program. TMHCA also owns and operates a Memphis-based Peer Center.

- TN Suicide Prevention Network: TSPN oversees a statewide suicide prevention hotline, survivor support groups, and staff training in suicide prevention.

- Peer Support Centers: Forty-nine consumer-run centers provide self-directed recovery opportunities targeted toward illness management and community reintegration.

Activities to Reduce Hospitalization:

- Crisis Stabilization: Five locations provide triage, referral and stabilization services for medically stable adults who present in a psychiatric crisis and are assessed as needing a level of care greater than respite but less than inpatient psychiatric hospitalization.

- Targeted Transitional Support: Funds assist persons eligible for discharge from the RMHIs to move to community settings with temporary transitional support until their financial benefits/resources are established.

- Mandatory Prescreening Law: A pre-screening evaluation for eligibility for emergency involuntary admission to RMHIs is completed by any of nearly 600 trained agents across the state. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis.

- Mobile Crisis Response Services: Crisis response services are available 24/7 in every county in Tennessee and include access to crisis respite beds.

- Intensive Long term Support: For adults with a history of repeated rehospitalization with minimal community tenure, intensive long-term support services were developed in the Chattanooga area designed to maintain discharged service recipients in the community in supportive living facilities. Funds provide a wide variety of services and supports that complement traditional services, which have not sufficiently met the specialized needs of these individuals.

All services under Criterion 1 have been implemented. A continuing theme of recovery is infused into all provider training to ensure the development of outcome measures that include consumer movement toward their goals.

Tennessee

Adult - Transformation Efforts and Activities in the State in Criteria 1

Adult - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities Related to Criterion 1: (Numbers correspond to goals and recommendations outlined in the President's New Freedom Commission on Mental Health report, *Achieving the Promise*.)

1.1: Advance a campaign to reduce the stigma of seeking care and a strategy for suicide prevention.

- The DMHDD Commissioner's multi-year "Overcoming Stigma Campaign" continues to educate the public and increase awareness of the impact and cost of untreated mental illness. Target audiences are representatives from businesses, insurers, chambers of commerce, mental health associations, city/county leaders, governments and consumer/family stakeholders. The Commissioner addressed more than 1,000 community leaders during the FY07 campaign.

- The "Arts for Awareness" Project, supported by funding from local CMHAs, the Tennessee Arts Commission, the Metropolitan Arts Commission of Nashville, and DMHDD, celebrates artwork by Tennesseans living with mental illness and substance abuse disorders who find art and creative activities an important part of recovery. During the two-year project, artwork is exhibited at a variety of community locations.

- The "In Our Own Voice" collaboration between NAMI and the TN Mental Health Consumer Association (TMHCA) has been very successful. Further efforts include publication of consumer success stories in departmental publications and local media, educational efforts within the faith-based community, and advocacy efforts for insurance parity.

- The Office of Housing Planning and Development addresses and combats discrimination of persons with mental illness and co-occurring disorders, including "Not In My Back Yard" (NIMBY) issues, that threaten the fair housing and other rights of persons with mental illness and co-occurring disorders residing in Tennessee neighborhoods or discrimination in the workplace.

- The Tennessee Suicide Prevention Network (TSPN), www.tspn.org, continues to work through eight regional suicide prevention network groups across the state. The network carries out their work through eleven strategies targeted to impact suicide rates in Tennessee: 1) promote awareness, 2) broaden support, 3) reduce stigma, 4) develop prevention programs, 5) reduce lethality access, 6) recognize risk, 7) promote effective clinical practices, 8) improve access to treatment, 9) improve media portrayal of suicide and mental illness, 10) promote research, and 11) improve and expand surveillance systems.

  ASIST (Applied Suicide Intervention Skills Training) is a two-day intensive, interactive, and practice-dominated course designed to help caregivers recognize and estimate risk and learn how to intervene to prevent the immediate risk of suicide. The network uses this gatekeeper training to help all caregivers become more comfortable, competent, and confident when dealing with persons at risk.

  TSPN supports two 24/7 hotlines and promotes the development of Suicide Anonymous (SA) and Survivors of Suicide Attempts (SOSA) support groups, self-help programs for mutual support based on the model of Alcoholics Anonymous. DMHDD also promotes the prevention of depression and suicide in older adults by distributing information tailored to that population.

- Presentations on mental health and suicide prevention have been arranged for students at UT and TSU schools of social work with further presentations scheduled.

2.1: Develop an individualized plan of care and 2.2: Involve consumers and families in orienting the mental health system toward recovery.

- The Tennessee Outcomes Measurement System (TOMS), which began in September 2006, is a consumer/family survey system that allows for a more systematic participation in treatment planning for service recipients. The survey is administered four times during the first twelve months of treatment and reports on a number of clinical, functional, and quality of life issues. Results can be used to measure change over time and to focus on clinical, support, or quality of life issues identified by the service recipient.

- Two self-directed care awards of $100,000 each have been awarded to a CMHA in Memphis and a Psychosocial Rehabilitation Program in Chattanooga. These pilot programs allow consumers to develop a purchasing plan for items and services that enhance their individual recovery plans. This innovative approach to the provision of mental health services can be a key component of successful recovery. The pilots are expected to serve approximately seventy adults with SMI.

- About half of the forty-nine Peer Support Centers across the state have consumers who are trained to assist other consumers to develop their own Wellness Recovery Action Plan (WRAP). WRAP is a structured system to monitor symptoms, carry out planned responses, and determine treatment and support needs and choices for when symptoms make it impossible for persons to make those decisions. WRAP enables consumers to develop a blueprint for personal recovery and self-management that incorporates wellness tools and strategies into their lives.

  DMHDD is investigating Real Choice Systems Change grant opportunities to utilize WRAP in a person-centered planning process with the nineteen CMHAs that provide services to persons eligible for TennCare. A minimum of two Peer Specialists per agency will be trained to conduct WRAP classes and seminars each year of the grant. Peer Specialists will teach the five key concepts of recovery and instruct on how to create, use, and update a WRAP to consumers receiving clinical services at the centers. They will coordinate the teaching of WRAP seminars with the consumer's therapist and case manager.

  A grant goal will be to train and certify 50 peer specialists connected with the CMHAs and 100 staff from the Peer Support Centers to conduct WRAP classes and seminars. An evaluation of outcome measures for participating service recipients is included in this project.

- By mid-October, all five RMHIs will have been provided educational training seminars on recovery principles and philosophy. The lead trainer for the seminars was Ike Powell from Georgia, an expert on the subject of recovery for mental health consumers. At the seminars, Ike presented an overview and introduction for staff on the principles and philosophy of recovery. Mental health consumers were present at each of the seminars and told their recovery story. A focus of these seminars was to discuss ways to implement recovery principles within the inpatient program.

  Additionally, a strategic goal for FY08 is to assist RMHIs in identifying current positions to convert to part-time peer support/recovery specialists.

- Magellan, a behavioral health contractor, and DMHDD co-sponsored a Resiliency and Recovery Symposium in November 2006. The overall theme for the Symposium was "Recovery/Resiliency-Building the Foundations for System Change." The vision and outcome for the Symposium was to build a common understanding that recovery and resiliency are real, possible, and achievable and to develop a shared commitment to transform the public mental health system to promote and support recovery and resiliency for all persons with mental illness or emotional disturbance.

  Approximately 400 persons were in attendance. The target audience consisted of consumers, family members, key policy makers and key staff within provider agencies including CEOs, clinical directors, and agency board members.

  The symposium was successful in achieving its stated goals. Staff from Magellan and the Department met in December 2006 to reflect upon the symposium and plan for building upon the momentum created. The managed care companies have since made the following initiatives:
  - Magellan hired a peer support specialist to work with a high-risk care management team, assist with WRAP, liaison with consumer organizations, and conduct education and outreach activities.
  - Magellan also awarded two self-directed care awards for pilots that allow consumers to receive financial support for non-TennCare covered components of their individual recovery plans.
  - AmeriChoice, an MCC, is conducting provider education on the peer support specialist role and principles of recovery-oriented services.
  - Amerigroup, an MCC, is seeking feedback from their advisory board to assist the heath plan in developing key strategies to promote recovery in network services.

  DMHDD will conduct recovery forums in each of the three grand regions during FY08 as a follow up to the successful statewide symposium. These smaller forums will provide an opportunity for more specific training on how agencies can implement recovery at the local level.

<u>2.3: Align relevant programs to improve access and accountability for mental health services.</u>

With the beginning of the Creating Jobs Initiative in FY06, a renewed collaboration has been formed with the Department of Human Services, Division of Vocational Rehabilitation Services (VR). This collaboration has, to date, resulted in many improvements for adults with mental illness seeking services through VR.

To date, these include:
- decreased lag time for priority eligibility determination;
- VR staff dedicated to DMHDD collaboration;
- for mental health consumers eligible for VR services, reimbursement for expenses related to successfully completing Illness, Management and Recovery, BRIDGES, or WRAP courses;
- VR closure status and provider reimbursement for 90 days of employment; and
- VR closure status for Peer Support Specialist positions.

2.5: Protect and enhance the rights of people with mental illnesses.

Staff training continues to be the primary approach to reducing the use of seclusion and restraint. Training has been an effective means of reducing much of the use of seclusion and restraint, thereby reducing the likelihood of physical and/or psychological trauma. Most seclusion and restraint use involves a very small number of persons for short periods of time.

DMHDD is considering changes in the training methods utilized at the RMHIs and has initiated a survey of the hospitals in the Southern States Psychiatric Hospital Association relative to training programs on management of aggressive behavior. Office of Hospital Services staff are currently in the process of obtaining additional information from select states about their state-developed training programs.

CMS and Joint Commission regulations now allow a Registered Nurse or a Physician's Assistant to conduct the face-to-face assessment following use of seclusion or restraint. State mental health law was amended to be consistent with this change, and DMHDD has drafted revisions to rules to reflect these changes. This is both a fiscal and safety issue, particularly in residential facilities, and increases the number of on-site staff qualified to assess the consequences of seclusion or restraint.

3.1: Improve access to quality care that is culturally competent.

A University of Tennessee at Memphis report on the benefits of learning a second language cites that over a quarter of a million Tennessee residents reported living in non-English speaking households for the 2000 census; one out of every twenty-eight households. Among southeastern states, Tennessee was second in growth of its Hispanic population projected into the year 2000. Various pamphlets, outcome and satisfaction surveys, and informational materials are provided in or are being translated into Spanish.

The State also has a well-established refugee relocation program, with persons of various African, Asian, and Eastern European ethnicities settling in cities across the state. DMHDD contracts with the Mental Health Association of Middle Tennessee (MHA) to promote cultural and linguistic competence within the statewide provider community. Benefits of a culturally and linguistically appropriate mental health system include: 1) reduced barriers to accessing care; 2) reduction and/or elimination of disparities in quality of care experienced by racial and ethnic minorities; and 3) enhanced provider understanding and utilization of individual and family culture to positively impact service outcomes.

For non-English speaking persons, service providers are required to assure the use of interpreters or translation resources as needed. MHA maintains a website listing of community agencies and organizations who have access to interpreter assistance and a list of nearly 200 interpreters and translators for some twenty-eight languages, including American Sign Language. Contract staff also provide educational programs to improve the knowledge of interpreters about mental health and to provide educational seminars to professionals on "How To Work With An Interpreter".

4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

DMHDD began cross-training of mental health and substance abuse staff in the integrated services model for COD in 1999. During subsequent years, best practices guidelines were developed, a COD recovery network and resource center was established, Dual Recovery Anonymous groups formed, and a COD information module was added to the BRIDGES curriculum.

In FY06, nearly 1,500 adults with SMI were reported to have received integrated services for COD. Strategies included in DMHDD's Three Year Plan to facilitate COD services include:

1.1.22 In FY08, through training of professionals throughout the state, DMHDD will facilitate COD awareness so that it impacts the expansion of integrated COD treatment in Tennessee.

4.2.5 In FY08, DMHDD will strive to facilitate and create additional COD services and programs.

With the return of substance abuse services oversight to the Department, programs are being reviewed to determine how best to integrate services throughout the service system.

5.2: Advance evidenced-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

In July 2006, training was conducted as part of a collaboration with the University of Pennsylvania. The training was the first in a two-part pilot that is centered around SAMHSA Evidence-Based Practices. The training was conducted by Dr. Kate Donegan with the Matrix Center @ Horizon House, Inc. and Norm Council with Northern Management Consultants.

Two train-the-trainer sessions were conducted in Shelby County using the CMHS Evidence Based Practice Illness Management and Recovery (IMR) Toolkit and the Supported Employment (SE) Toolkit. The training groups consisted of practitioners from service agencies in Shelby County, across the spectrum of service settings, including a significant contingent of consumer providers. The rational for this training format was the development of a cadre of trained practitioners who could foster the implementation of these important EBPs in their region.

A group of fifteen individuals completed a class on IMR. The same fifteen individuals participated in a second training in September 2006 on SE. Each participant is now certified to teach an IMR and SE class and track the results. The expectation is that the individuals will go back to their sites and train other staff and individuals in IMR and SE. Additional funding is currently being sought to provide for training opportunities in other areas of the State.

Tennessee

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

ii. Criterion 2 Mental Health System Data Epidemiology

Tennessee utilizes the federal definition for its adult priority population: “An individual age eighteen and over who currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.” The degree of functional impairment is rated by using a Clinically Related Group (CRG) assessment form. Assessments are done by DMHDD approved raters from authorized CMHAs and RMHIs.

The assessment is based on diagnosis, severity of impairment in four domains (Activities of Daily Living; Interpersonal Functioning; Concentration, Task Performance and Pace; and Adaptation to Change), duration of impairment; and need for services to prevent relapse. Based on the assessment, a rating of 1-5 is assigned. Those with a CRG rating of 1, 2, or 3 are considered either SMI or SPMI, based on duration and severity of impairment, and are included in the mental health adult priority population.

A prevalence rate of 5.4% of the state’s population of individuals age 18 and over results in an estimate of 242,589 persons. The annual penetration rate is defined as the number of adults identified as SMI and engaged by the public mental health system through TennCare, MHSN, state only, or judicial services funding streams during the fiscal year. For FY06, that number was limited to TennCare and was 196,858, or a penetration rate of 81%.

Tennessee

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Adult - Quantitative targets.

During FY08, DMHDD community contracts are expected to provide direct services and supports to over 35,500 unduplicated adults and family members; over 7,000 of them through Block Grant funded initiatives. Further quantitative goals are included in the Adult Goals, Targets, and Action Plan section.

Tennessee

Adult - Transformation Efforts and Activities in the State in Criteria 2

Adult - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities Related to Criterion 2: (Numbers correspond to goals and recommendations outlined in the President's New Freedom Commission on Mental Health report, Achieving the Promise.)

4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

A sub-group of priority population adults are those with a co-occurring disorder of mental illness and substance abuse/dependence. A 2004 National Survey on Drug Use and Health (NSDUH) Report states that about 23% of adults identified as SMI in 2002 had a co-occurring disorder. In Tennessee, that would result in an estimate of nearly 20,500 adults. In FY06, approximately 14% of adults with SMI served through the TennCare Partners Program also had a diagnosis of substance abuse. (URS Table 12)

Additionally, the NSDUH report indicated that over half of those adults with a COD received neither specialty substance use treatment nor mental health treatment within the past year. In Tennessee, over 47% of adults diagnosed with COD received mental health services but no TennCare-covered inpatient or outpatient substance abuse service. Some of these adults may have received substance abuse services provided under the DADAS block grant.

Persons with either a primary or secondary substance use diagnosis accounted for 51% of persons discharged from the RMHIs in FY06 and 44% of persons readmitted within 30-days.

RMHIs routinely screen for co-occurring disorders as part of the admissions process. Joint accreditation standards now require this. RMHI policy and procedures require discharge planning and referral to appropriate community services for all diagnosed active conditions. Behavioral health care standards require that a MH/SA screen be done by all contract providers and referrals be made for treatment if the screen identifies an issue.

Tennessee

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

iv. Criterion 4 Targeted Services to Rural, Homeless and Older Adult Populations

Homeless

The TCPP provides a continuum of services for all eligible individuals with SMI. Homeless persons who meet the eligibility criteria may receive TennCare using agency addresses, shelter addresses, or Post Office boxes. Homeless persons who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost consumer and family support groups and Peer Support Centers at various locations throughout the state. Homeless persons with SMI may receive inpatient and/or outpatient clinical treatment through 'judicial' or 'state only' funding options.

DMHDD is largely dependent upon federal PATH grant support to provide outreach and case management services to homeless adults. PATH currently consists of ten projects, five of them serving smaller cities and rural counties. The PATH project goal for FY08 is 3,400 persons served through outreach with 2,030 opened cases.

In addition to the PATH program, there are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. The sites are located in three urban areas: Chattanooga, Nashville, and Knoxville. Chattanooga has two sites with housing capacity of sixteen adults. Nashville has four sites with housing capacity for fourteen adults; the Knoxville site serves women with dependent children.

Regional SETH facilitators work closely with PATH programs to develop housing options for adults with SMI or COD who are also homeless. The state provides supplemental dollars to assist agencies in PATH and permanent housing ojects.

DMHDD participates in the SOAR (SSI/SSDI Outreach, Access, and Recovery) project for improving access to mainstream services for people experiencing chronic homelessness. SOAR is a train-the-trainer technical assistance initiative designed to increase access to government benefits for homeless people with disabilities, including those with serious mental illnesses and co-occurring disorders.

Tennessee

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

iv. Criterion 4 Targeted Services to Rural, Homeless and Older Adult Populations

Rural

DMHDD defines a “rural county” as one that has 50% or more of its population in a rural area and is not included in the Metropolitan Statistical Areas list. This definition results in fifty-nine of ninety-five counties meeting the criteria for rural. This information is obtained from the 2003 Tennessee Statistical Abstract.

TCPP policies require equal eligibility, service coverage, and availability statewide to both urban and rural Tennessee residents. TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations. Non-clinical service initiatives like Peer Support Centers and consumer support groups are located in rural areas with transportation provided for access.

A critical issue for rural residents is their ability to access medical or mental health specialists. Several rural-based CMHAs participate in the federal rural recruitment and retention plan to hire psychiatrists and psychologists. In addition, forty-two telemedicine sites have the capacity to provide increased access and availability to physician services for those living in rural areas where Tennessee has the greatest psychiatrist shortages. Staff monitor telehealth access through review of agency requests and encounter data. The BHOs educate providers on the appropriate utilization of telehealth and promote and encourage its use.

The DMHDD Division of Managed Care maintains geoplots of MCC service providers and monitors geographical access to emergency, urgent and routine care. However, geographical access may not always equal actual access due to provider capacity. When disparities occur, the issue then becomes a point of contract negotiation for provider expansion in a needed area.

Rural service planning must also take into account the routine travel patterns of rural populations for other services (e.g., shopping, banking, recreational, etc.) to provide convenient access to behavioral health services. One east TN CMHA, Cherokee Health Systems, has totally integrated health services at their twenty-three, largely rural sites across thirteen counties, providing medical, dental and behavioral health care within one setting. The Agency provides conferences and consultation on the clinical, operational and financial aspects of integrated care.

Tennessee

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

iv. Criterion 4 Targeted Services to Rural, Homeless and Older Adult Populations

Older Adults

Recognizing the reluctance of older adults to access traditional mental health services, DMHDD provides funding for and oversight of four Older Adult Projects that provide outreach, screening, assessment, integrated medical and mental health treatment, in-home services to homebound persons, and linkage and support services to persons age 55 and over with mental health needs. These projects also provide community mental health education to promote awareness and knowledge about geriatric mental health concerns and collaborate with community agencies to implement better ways of delivering mental health services to the geriatric population.

The Tennessee Geriatric Initiative, coordinated by staff of the DMHDD Division of Special Populations, advocates for and assists in the development of state and local efforts toward services to older adults. Activities include:
o Providing education and training for persons working in geriatric mental health.
o Exploring treatment options including integrated mental health and primary health care delivery.
o Providing educational and outreach activities including awareness of treatment and its effectiveness.
o Providing education directed at identifying mental health needs of older adults such as high suicide rates, depression and dementia.
o Identifying and securing potential new sources of funding to support existing and expanding services.
o Facilitating the recommendations of older adult coalitions across the state.

DMHDD uses Olmstead grant funding to support the development of older adult coalitions across the state. These coalitions have a stated purpose to reduce the stigma of mental illness in older adults, identify unmet needs for older adults, advocate for increased availability of specialized geriatric services initiatives, and increase public awareness of mental health issues and services available.

Additionally, DMHDD oversees the Older Adults Substance Abuse Treatment (OATS) Grant to identify, engage, assess and provide a comprehensive continuum of care for adults aged 50 and older who are abusing alcohol or other drugs, including prescription and over-the-counter medication, in the Greater Nashville area.

DMHDD also contracts for and oversees the PASARR process for individuals in nursing homes or seeking nursing home admission who have a mental illness or a developmental disability.

Tennessee

Adult - Transformation Efforts and Activities in the State in Criteria 4

Adult - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities Related to Criterion 4: (Numbers correspond to goals and recommendations outlined in the President's New Freedom Commission on Mental Health report, Achieving the Promise.)

2.3: Align relevant programs to improve access and accountability for mental health services.

In FY07, DMHDD was a recipient of a technical assistance (TA) grant to develop a housing first/employment fast strategy to end chronic homelessness. Due to change in vendors at the federal level, the delivery of this TA was postponed into FY08. The initial phase of the TA will be a conference for statewide homeless program directors aimed at using evidenced based practices and full implementation of SOAR. The conference is scheduled for August 29-30, 2007 and will be open to stakeholders statewide. This will be followed by focused TA in Nashville, Knoxville, and Memphis.

3.2: Improve access to quality care in rural and geographically remote areas.

DMHDD staff are meeting with rural hospitals that provide inpatient psychiatric services to explore the possibility of increasing bed capacity to serve TennCare enrollees in rural areas within their home communities. Models to provide an array of crisis stabilization services in rural areas are also being reviewed. One of the three new crisis service programs in the Middle Tennessee area serves a rural county.

6.1: Use health technology and telehealth to improve access and coordination of mental health care, especially for remote areas or underserved populations.

DMHDD promotes state of the art diagnostic systems such as telemedicine to increase response time for diagnosing patients, reduce stressors on the persons with a potential mental illness, and reduce transportation costs.

Currently, forty-two telemedicine sites have the capacity to provide increased access and availability to physician services. To enhance the use of this technology, DMHDD developed a telemedicine work group to assess barriers for utilization and promote telemedicine services statewide. A survey was conducted with CMHAs and RMHIs across the state. The information from these surveys is being reviewed to determine next steps in overcoming barriers to increase utilization of telemedicine services for the purpose of improving access and availability to behavioral health services.

Tennessee

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Financial Resources, Staffing and Training

Tennessee made available $406,235,800 in capitation payments made monthly to the BHOs for services provided to TennCare Partners Program enrollees through June 30, 2007.

The State continued the financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees that it assumed in 1999. The pharmacy cost for individuals for FY07 in the community amounted to $213,581,629 with medications for individuals during inpatient stays included in the inpatient rates received by the respective inpatient facilities.

The cost of providing forensic and court ordered evaluations performed at the five RMHIs and in the community is estimated at $28,071,450.

DMHDD funded community mental health services, excluding forensic and court ordered evaluations, at $41,878,782. This funding includes the CMHS Block Grant award and other federal grants received by the DMHDD.

Further, the five RMHIs expended $94,903,863 above revenue received to provide inpatient mental health services.

In total, roughly $784,671,524 was directed for the provision of mental health services to individuals within Tennessee for FY07.

DMHDD enters into grant agreements to provide a Clinical, Therapeutic and Recovery Services package for priority population adults who lost TennCare benefits, and contracts for other service initiatives outside the scope of services provided under the TCPP. Funds are administered through individual grants with CMHAs and other agencies, various Delegated Purchase Authorities for specific services, and additional interdepartmental funds made available to supplement federal grants awarded to Tennessee.

Staffing

DMHDD employs approximately 2,900 staff; some 2,600 in the five state psychiatric hospitals and the remainder in the Central Office.

State contracts with the managed care organizations require those entities to maintain an adequate network to provide behavioral health services to individuals covered under the benefit plan. The managed behavioral health care outpatient network currently consists of around 1,200 credentialed and contracted individual and group providers, exclusive of individual CMHA staff.

Additional resources for adults include:
16 providers of 24-hour residential treatment at 66 locations
28 providers of inpatient psychiatric services at 32 locations
23 providers of inpatient substance abuse services at 29 locations
13 providers of crisis response services in 95 counties

Training

MCC consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee’s managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires MCCs to offer the following:
1) an educational plan for providers formulated with input from the MCC Advisory Board; (Boards must have minimum 51% family and consumer membership

and consumers and family members must be included as trainers.)
2) cross-training of mental health and substance abuse providers;
3) mental health training for primary care providers; and
4) assurance that providers are appropriately licensed, certified, accredited, approved
and/or meet DMHDD standards, whichever is appropriate.

The TN Association of Mental Health Organizations (TAMHO) provides annual conferences and continuing professional development opportunities at workshops and on-line for the provider community.

DMHDD provides routine training and networking opportunities for coordinators of DMHDD grant programs, including annual certification training for forensic evaluators. In addition to routine networking opportunities and technical assistance, DMHDD sponsors, supports, or provides a variety of training events for community providers, family and consumer groups, and special grant recipients.

Tennessee

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Adult - Training Providers of Emergency Health Services

Under the TCPP, mental health staff of crisis response services are in regular contact with providers of emergency health services. Crisis services are funded by the BHOs and are available to emergency health staff twenty-four hours a day, 365 days a year.

Crisis staff provide on-going consultation and information on mental health crisis intervention strategies and service alternatives. DMHDD provides training in mandatory pre-screening to eligible mental health professionals. Criminal Justice/Mental Health liaisons provide training in mental health to transportation agents, law enforcement personnel and court officers across the state.

DMHDD provides for certified Critical Incident Stress Management training courses for peer first responders and mental health staff to maintain responsibilities in the TN Emergency Management Plan.

The DMHDD Emergency Services Coordinator (ESC) provides presentations on all-hazard mental health interventions to local community civic organizations, county CERT (Community Emergency Response Team) volunteers, and community behavioral health staff and other paraprofessionals during times of disaster.

ESC and CMHA emergency response staff participate with other agencies conducting all-hazards preparation, response, and mitigation activities, including Department of Health bioterrorism, mass casualty and pandemic response exercises.

Tennessee

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Expenditure of 2008 Block Grant Allocation

The 2008 Block Grant projected allocations are based on the final 2007 award amount of $7,896,737 for Tennessee. Ninety-five percent (95%) of the total award will be granted to community based programs in accordance with the expectations of the block grant. Approximately 5% of the award, or $394,836, supports administrative functions relative to the community mental health system and Mental Health Planning and Policy Councils' support and activities. Despite recent decreases in the Block Grant award, DMHDD has not decreased program allocations, utilizing an early withdrawal of the next year's Block Grant funding as necessary. (See Table A)

DMHDD utilizes its Block Grant funding for the provision of services not provided or fully supported by TennCare. Services are designed to impact the adult priority population by reducing over utilization of hospitalization, promoting education, empowerment, and participation in treatment, and building a reliable community support service system that emphasizes recovery and community reintegration.

Currently, fourteen private, not-for-profit CMHCs and five other community agencies receive federal mental health block grant funds to provide services to adults. Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.)

Some $5,167,300 of CMHS Block Grant funding is projected to be allocated for adult services in accordance with Criterion 1, 2, 4 and 5 in the following manner:

Assisted Living Housing **$ 210,000**
Assisted living fills the gap in the continuum of housing available for adults with SMI who do not require the supervision of a Supportive Living Group Home, but do not yet possess the necessary skills for independent living. The programs consist of clustered apartment units, with one unit occupied by a live-in "assisted living specialist". The specialist is a consumer whose role is to serve as a mentor to and provide support for the other residents. The goal is to assist the consumer in a smooth transition to independent living. Funds support six assisted housing projects.

Criminal Justice Project **$ 476,000**
Projects provide activities targeted toward individuals with SMI or co-occurring disorders interfacing with the criminal justice system. Services include liaison/case management services, diversion activities, cross-training and education, and appropriate referral and linkage to follow-up services in the community. Goals are to enhance systems collaboration and cooperation, decrease recidivism, and ensure access to appropriate services. Block Grant funds, supplemented by $373,600 in state funding, provide eighteen liaisons serving twenty-three counties.

Consumer Support / BRIDGES **$ 226,500**
Funds are provided to the TN Mental Health Consumers Association (TMHCA), via the Tennessee Disability Coalition, to support regional advocacy staff and on-going development of the BRIDGES educational program for mental health consumers.

Cultural Competency **$ 21,800**
Cultural and linguistic competency promotion is targeted for mental health agencies, mental health providers, and mental health interpreters.

Older Adult Project **$ 280,000**

These projects provide professional mental health counseling and peer counseling to adults age fifty-five and over who are homebound or otherwise unable or unwilling to access traditional mental health services. Services may be offered in the individual's home or at a primary care site accessed by older adults. Staff either provide or refer individuals to the appropriate level of mental health services. Services are provided in collaboration between a CMHC and the aging community service system. Funds support four programs.

Peer Support Centers (PSC) **$ 3,953,000**

A PSC is a place where persons who have received treatment for mental illness develop their own programs to supplement existing mental health services. Members address issues such as social isolation and discrimination and provide opportunities for socialization and personal and educational enhancement. PSCs conduct recovery-based services and programs that promote the involvement of consumers in their own treatment and recovery and assist consumers in acquiring the necessary skills for the utilization of resources within the community. Programs include training for Peer Support Specialist certification and WRAP. Funds, supplemented with $672,160 in state funding, support forty-nine programs serving eighty-one of ninety-five counties.

Table A details the proposed 2008 Block Grant allocations for adult services by agency and program.

Table A. 2008 BLOCK GRANT FUNDS FOR ADULT SERVICES

PROJECTED ALLOCATION DATE JULY 1, 2008

CMHC	Assisted Living	Criminal Justice	BRIDGES / Cultural Competency	Older Adult	Peer Support Center	Total
Frontier	140,000	40,000	0	70,000	462,300	$712,300
Cherokee	0	0	0	0	51,400	$51,400
Ridgeview	0	0	0	0	308,200	$308,200
HR McNabb	0	50,000	0	0	113,200	$163,200
Peninsula	0	0	0	0	154,100	$154,100
Volunteer	0	90,000	0	70,000	986,500	$1,146,500
Fortwood	0	0	0	0	113,200	$113,200
Centerstone	0	105,000	0	70,000	726,200	$901,200
Carey	0	40,000	0	0	308,200	$348,200
Pathways	0	0	0	0	205,500	$205,500
Quinco	0	0	0	0	205,500	$205,500
Professional Care Services	0	0	0	0	205,500	$205,500
Southeast	0	0	0	0	113,200	$113,200
Frayser	0	0	0	70,000	0	$70,000
OTHER AGENCY						
Mental Health Association	0	0	(CC) 21,800	0	0	$21,800
Mental Health Cooperative	35,000	50,000	0	0	0	$85,000
Park Center	35,000	0	0	0	0	$35,000
Shelby Co. Govt.	0	101,000	0	0	0	$101,000
TN Disability Coalition	0	0	226,500	0	0	$226,500
Total Adult	**$ 210,000**	**$ 476,000**	**$ 248,300**	**$ 280,000**	**$3,953,000**	**$ 5,167,300**
Total C&Y						$ 2,484,200
Total Both						**$ 7,651,500**
Admin. 5%						$394,836
[a] Total Allocation						**$ 8,046,336**

[a] Total allocation exceeds amount of 2007 Block Grant Award ($7,896,737). The shortfall is expected to be accommodated by early expenditure from the anticipated 2009 Block Grant allocation.

Table 4
FY 2008 – FY 2010 MHBG Transformation Expenditures Reporting Form
State: Tennessee

Number	State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
1	Improving coordination of care among multiple systems	621,000	373,600
2	Support for culturally competent services	26,800	17,400
3	Involving consumers and families fully in orienting the MH system toward recovery	0	0
4	Support for consumer- and family-operated programs, including Statewide consumer networks	4,227,000	1,383,601
5	Services for co-occurring mental and substance use disorders	4,000	521,640
6	Eliminating disparities in access to and quality of care	280,000	17,763,000
7	Support for integrated electronic health record and personal health information systems	0	0
8	Improving consumer access to employment and affordable housing	210,000	4,899,250
9	Provision of Evidence Based Practices	0	0
10	Aligning financing for mental health services for maximum benefit	0	2,083,686
11	Supporting individualized plans of care for consumers	0	937,800
12	Supporting use of peer specialist	0	0
13	Linking mental health care with primary care	0	0
14	Supporting school mental health programs	0	200,000
15	Supporting early mental health screening, assessment, and referral to services	1,600,500	1,186,041
16	Suicide prevention	95,500	128,000
17	Supporting reduction of the stigma associated with mental illness	0	110,000
18	Use of health technology and telehealth to improve access and coordination of mental health care	0	0
19	Supporting workforce development activities	0	13,000
20	Other (specify) Community Alternatives to Inpatient Care	555,600	8,087,990

No.1. Coordination of care between multiple systems includes both system of care for children and criminal justice/mental health liaison services for adults.

No.2. Contract to develop a culturally competent workforce and mental health informed interpreter/translation support.

No.3. Efforts are described under NFC Goal 2.2 in Transformation Activities section of Adult Criterion 1 - general Departmental budget supports conferences, education and training to promote recovery philosophy.

No.4. Includes support of NAMI, TMHCA, BRIDGES and TVC.

No.5. COD case managers and funding of education and training to promote integration of services.

No.6. Eliminating disparities in access to care includes older adult outreach and services to individuals without healthcare coverage.

No.7. DMHDD is working toward an electronic health record for state psychiatric hospitals.

No.8. Assisted living, permanent housing, creating housing and job initiatives, housing facilitators and consumer specialists, independent living subsidies and web based housing site.

No.9. EBPs, integrated care, and health technology/telehealth services are provided through the managed care capitated contract. General Departmental budget supports conferences, education and training to promote and support development.

No.10. Aligning finances for mental health benefit includes interdepartmental allocations with VR and DD and suspender funding to sustain service levels impacted by new middle TN contractor.

No.11. Funding to provide level of specialized services and supports determined necessary by individual plans of care for successful community tenure of adults with SMI.

No.12. Support for Peer Specialists is provided through funding for the consumer-run Peer Support Centers under #4. General Departmental budget supports training and certification activities through Office of Consumer Affairs.

No.13. Individual CMHAs integrate primary and mental health care to varying degrees - Middle TN managed care contract is a carve-in program.

No.14. School-based mental health liaisons in one county.

No.15. BG funded sreening, assessment and referral program is provided in an elementary school setting.

No.16. Seventy-five percent (75%) of BG funded suicide prevention services are provided in a school setting.

No.17. Anti-stigma activities are promoted through activities of the Commissioner's Office and the Office of Public Information and Education through the general Departmental budget. Activities are described under NFC Goal 1.1 in Transformation Activities section of Adult Criterion 1.

No.18. See Transformation Activities section of Adult Criterion 4.

No.19. See Criterion 5 for DMHDD and MCC workforce development activities. See Transformation Activities section of Adult Criterion 1 for additional workforce development efforts in recovery/resiliency and EBPs.

No.20. Alternatives to inpatient care includes community crisis stabilization services and planned respite for caregivers of children and youth.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	139,809	122,072	123,072	123,172	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To maintain access to publicly funded behavioral health care for adults.

Target: To serve an additional 100 adults through publicly funded behavioral health care.

Population: Adults receiving publicly funded behavioral health services.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Unduplicated number of adults served by age, gender and race/ethnicity.

Measure: Number

Sources of Information: Source: DMHDD, Division of Managed Care, MHSN Annual Data, URS Table 2A

Special Issues: Publicly funded services include clinical services provided under the TennCare Partners Program and the MHSN.

Significance: Publicly funded services include clinical services provided under the TennCare Partners Program and the Mental Health Safety Net Services Program. As of August 2005, DMHDD is contracting directly for clinical services to TennCare disenrolled adults.

Action Plan: As part of TennCare reform, disenrollment of the waiver population began in August 2005. As of June 30, 2007 TennCare enrollment was under 1.2 million, comparable to enrollment of ten years ago. As a percent of total TennCare enrollment, adult enrollees dropped from 58% in July 2003 to 50% in June 2007. As expected, the number of adults receiving behavioral health services through the TennCare Partner's program decreased by about 21% following waiver population disenrollment, from 139,809 to 109,769. MHSN services for priority population disenrollees served an additional 12,303 adults or 41% of the decrease from FY05 to FY06.

Non-priority population adults comprise approximately 90% of the total adult TennCare population and accounted for about 30% of persons receiving behavioral health services under that program in FY06.

For those retaining TennCare enrollment or becoming Medicaid eligible, community education about TennCare eligibility and access to services is provided regularly through Bureau of TennCare, MCC, DMHDD and community consumer, family and legal advocacy group efforts. Disenrollees are expected to be prioritized for health care coverage under the Cover Tennessee initiative.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	10.86	10.69	11	11	N/A	N/A
Numerator	800	555	--	--	--	--
Denominator	7,365	5,193	--	--	--	--

Table Descriptors:

Goal: To assure effective inpatient treatment and continuity of care to maximize community tenure.

Target: Determine baseline readmission rate to state psychiatric hospitals within 30 days of discharge.

Population: All persons age 18 and above discharged from and readmitted to state psychiatric inpatient service.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adults discharged who are readmitted within 30 days.

Measure: Numerator: Number of persons age 18+ who are readmitted to a state hospital (RMHI)within 30 days of discharge.
Denominator: Number of persons age 18+ discharged from a state hospital (RMHI) during the previous fiscal year.

Sources of Information: DMHDD, Office of Hospital Services, URS Table 20A

Special Issues: Readmission is defined as admission to any RMHI within 30 days of a discharge from any RMHI. This data would not reflect an admission to a private hospital within the 30-day post RMHI period. Data includes all payor sources and legal codes.

Significance: A major outcome of a comprehensive, community-based mental health system of care is the effectiveness of inpatient treatment.

Action Plan: This indicator has previously been measured using the TennCare enrolled population only. That readmission rate has been just below 11% since FY05.

State psychiatric hospitals are the only inpatient option available for persons without health care insurance. A prior DMHDD study of hospital readmissions found the most prevalent reason to be the discontinuance of medications. For those without health insurance, a state-only funding option allows for referral and continued outpatient care for a six-month period, allowing for the determination of Medicaid eligibility and/or other entitlements. Staff may also access various pharmacy assist programs to help individuals continue recommended medications post discharge.

Since TennCare reform, the number of adults with TennCare accessing state hospitals has declined. Therefore, the population for the FY08 indicator has been changed to any adult discharged from a state hospital. TN completes both URS Tables 20A (readmission to state hospitals) and 21 (readmission to any hospital). Results can be used to compare readmission rates between state and private hospitals and determine if results differ substantially for these respective populations.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	21.34	20.84	21	21	N/A	N/A
Numerator	1,572	1,082	--	--	--	--
Denominator	7,365	5,193	--	--	--	--

Table Descriptors:

Goal: To provide effective continuity of care and outpatient services and supports that maximize community tenure.

Target: Determine baseline readmission rate to state psychiatric hospitals within 180 days of discharge.

Population: Persons age 18 and above discharged from and readmitted to state psychiatric inpatient service.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adults discharged from inpatient services in FY07 who are readmitted within 180 days.

Measure: Numerator: Number of persons age 18+ who are readmitted to a state hospital (RMHI) within 180 days of discharge.
Denominator: Number of persons age 18+ discharged from a state hospital (RMHI) during the previous fiscal year.

Sources of Information: DMHDD, Office of Hospital Services, URS Table 20A

Special Issues: Readmission is defined as admission to any RMHI within 180 days of a discharge from any RMHI. This data would not reflect an admission to a private hospital within the 180-day post RMHI discharge period. Data includes all payor sources and legal codes.

Significance: A major challenge in a comprehensive community-based mental health system of care is the development of community-based crisis services including short term alternatives to inpatient treatment.

Action Plan: This indicator has previously been measured using the TennCare enrolled population only. That readmission rate has been approximately 21% since FY05.

Community alternatives to hospitalization are a high priority for continued development in the Tennessee system. The objective is to stabilize adults experiencing a psychiatric crisis who need a level of care greater than respite. Goals are to strengthen or develop support systems and coping skills while allowing the individual to remain in the community. Currently, seven crisis stabilization programs operate under the managed care system across the state. Crisis response services also have facility, home and hospital based crisis respite beds available to provide a brief time of rest and support to stabilize or alleviate a less serious crisis situation.

Individual WRAP and crisis intervention plans are also used to promote the early intervention of adequate treatment and support services to enable maximum consumer participation in treatment and recovery and avoid the need for rehospitalization.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	6	5	7	6	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide all SAMHSA-recommended EBP services.

Target: Maintain availability of behavioral health interventions having consistent, scientific evidence showing improved consumer outcomes.

Population: Adults assessed as SMI.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of SAMHSA-defined evidenced based practices provided in Tennessee.

Measure: Number

Sources of Information: DMHDD, CMHA Survey, Division of Managed Care, URS Tables 16-17

Special Issues: States may be providing other best practices not included in the URS table listing.

Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Action Plan: Current URS Developmental Tables 16-17 list the following Evidenced Based Practices for adults:

1. Supported Housing (SH)
2. Supported Employment (SE)
3. Assertive Community Treatment (PACT)
4. Family Psychoeducation (FP)
5. Integrated Treatment (IT)
6. Illness Management and Recovery (IMR)
7. Medication Management (MM)

Tennessee has supported approved models of supported housing and supported employment for many years. There are HUD supported housing sites and supported housing funding through the Creating Homes Initiative. Supported employment opportunities are available at all Psychosocial Rehabilitation Programs. There are currently two PACT teams operated under the managed care system, but no available funding to expand either team capacity or add additional teams.

NAMI-TN does provide the With Hope in Mind curriculum and some facilities provide family education and support groups for their service recipients and caregivers, but these efforts do not fully meet the evidenced-based model criteria for Family Psychoeducation. It is noted that the FP model is a part of the TN Medications Algorithm Project (TNMAP), but is currently limited to one inpatient facility with limited community participation. The EBP model of Medication Management is also practiced through TNMAP.

A number of CMHAs have either fully integrated treatment for COD or provide integrated services programmatically.

The existence of EBPs is verified in different ways. SE is a service that must be offered through licensed Psychosocial Rehabilitation Programs. PACT utilization is monitored by the managed care contractor. MM can be verified through the TNMAP project. For the others, no reporting mechanism exists. A provider survey, which lists the model service description and the minimum fidelity criteria required for reporting is currently used. While the number of persons being served is included in the survey response, it is noted that this reporting method is not a reliable indicator of the clinical or cost effectiveness of the model. As part of DIG grant activities, a workgroup discussed strategies to access EBP information. Currently, at least in Tennessee, no other method appears to be a viable alternative to a provider survey for those services not specifically offered as part of a funded program.

Survey results in 2005 reported activities for all listed EBPs except medication management, which was not included on the survey. However, that survey did not include fidelity criteria. Results from the 2006 survey, which did include minimum fidelity criteria, indicated that all EBPs except Family Psychoeducation were available through one or more community providers. Therefore, six of the seven listed EBPs are offered within the behavioral health system as a whole.

For FY08, DMHDD will report on the four most widely available EBPs: supported housing, supported employment, integrated treatment, and illness management and recovery.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	570	754	784	800	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide necessary supports to allow housing of choice for consumers.

Target: To provide supported housing services to at least 800 adults.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults receiving SAMHSA-defined supported housing services in FY08.

Measure: Number

Sources of Information: Provider survey, CHI Annual Report, URS Table 16

Special Issues: Stable, affordable housing of choice is a strong indicator of improved psychiatric stability and quality of life.

Significance: Access to appropriate housing is a challenge that faces all lower and middle income families in Tennessee. Persons with low or fixed incomes, especially those receiving SSI or SSDI, are generally “priced-out” of the housing market.

Action Plan: Tennessee has promoted supported housing for many years. CMHAs were encouraged to assist consumers to access housing of their choice and provide the financial and social supports to enable them to succeed. However, housing shortages and prohibitive costs were deterrents to movement from institutes or supervised housing into more independent living situations. Available and/or affordable housing was often in unsafe areas or below codes. Efforts of the CHI have made strong gains in housing options available to consumers.

Two-thirds of CMHAs reported providing supported housing services in the FY06 provider survey. Over 90% of Independent Living Subsidy funds are disbursed for rent or utilities to assist consumers to attain and maintain housing of choice. Four assisted living projects provide four-apartment complexes with a peer mentor occupying one apartment to support other tenants to live independently.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	464	290	310	330	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide supported employment opportunities for adults with SMI.

Target: To increase by 20 individuals per year the number of consumers receiving the EBP of Supported Employment.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Reported number of consumers receiving SE services in FY08.

Measure: Number

Sources of Information: PRS quarterly reports and Provider Survey.

Special Issues: Decrease from FY05 to FY06 reflects the inclusion of fidelity criteria for reporting this EBP.

Significance: Employment is often voiced as the first priority of consumers working toward recovery.

Action Plan: To assist adults to gain and maintain employment of their choice is a primary goal of Psychosocial Rehabilitation Services, which have been funded in the state since the early 1990's. There are currently eighteen locations across the state. Other agencies may also have staff dedicated to supported employment.

In July 2006, a training was conducted as part of a collaboration with the University of Pennsylvania. The training was the first in a two-part pilot that is centered around SAMHSA Evidence-Based Practices. The training was conducted by Dr. Kate Donegan with the Matrix Center @ Horizon House, Inc. and Norm Council with Northern Management Consultants.

Two train-the-trainer sessions were conducted using the CMHS Evidence Based Practice Illness Management and Recovery (IMR) Toolkit and the Supported Employment (SE) Toolkit. The training groups consisted of practitioners from service agencies in the Memphis, Shelby County, area and included a significant contingent of consumer providers. The rational for this training format was the development of a cadre of trained practitioners who could foster the implementation of these important EBPs in their region.

A group of fifteen individuals completed the class on SE and is certified to teach an SE class and track the results. The expectation is that the individuals will go back to their sites and train other staff and individuals in SE. Additional funding is currently being sought to provide for training opportunities in other areas of the state.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: No PI is planned for Assertive Community Treatment teams. Two PACT teams operate under behavioral managed care and cannot extend beyond team capacity.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: No PI is planned for this measure. Not currently available meeting minimum fidelity measures.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	8,218	1,459	1,709	1,800	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide integrated mental health and substance abuse interventions within the public behavioral health services system.

Target: To increase by 100 individuals the number of consumers receiving the EBP of Integrated Treatment

Population: Adults with COD.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults receiving services through IT in FY08.

Measure: Number

Sources of Information: Provider survey, URS Table 17

Special Issues: Decrease from FY05 to FY06 reflects the inclusion of fidelity criteria for reporting this EBP.

Significance: Integrated treatment lessens barriers to access and provides care to the whole person as opposed to a diagnosed illness.

Action Plan: Since the early 2000's, DMHDD has promoted the integration of treatment for COD with the provider community through collaborative projects with Alcohol and Drug Abuse Services and through contract agencies in the community. Activities have included cross-training of mental health and substance abuse providers, establishment of COD resource centers, development of dual recovery anonymous groups, contract grants for specialized COD case management, and inclusion of substance abuse education in various education and support programs.

DMHDD also maintained a contractual agreement with a community provider to promote the concept of integrated services through training opportunities and consultation.

The recent return of the responsibility for the provision of substance abuse services to the Department will strengthen opportunities to encourage and promote integrated services.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	16,300	546	646	746	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To promote recovery through education and empowerment of consumers to participate in treatment and supports that assist in managing illness.

Target: To increase by 100 the number of consumers receiving IMR services.

Population: Adults with SMI

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Reported number of consumers receiving IMR curriculum.

Measure: Number

Sources of Information: Provider survey, URS Table 17

Special Issues: Decrease from FY05 to FY06 reflects the inclusion of fidelity criteria for reporting this EBP.

Significance: IMR assists consumers in accepting responsibility for their own recovery: physically, emotionally, mentally, and spiritually.

Action Plan: As stated under the SE Performance Indicator, In July 2006, a training was conducted as part of a collaboration with the University of Pennsylvania. The training was the first in a two-part pilot that is centered around SAMHSA Evidence-Based Practices. The training was conducted by Dr. Kate Donegan with the Matrix Center @ Horizon House, Inc. and Norm Council with Northern Management Consultants.

Two train-the-trainer sessions were conducted using the CMHS Evidence Based Practice Illness Management and Recovery (IMR) Toolkit and the Supported Employment (SE) Toolkit. The training groups consisted of practitioners from service agencies in the Memphis, Shelby County, area and included a significant contingent of consumer providers. The rational for this training format was the development of a cadre of trained practitioners who could foster the implementation of these important EBPs in their region.

A group of fifteen individuals completed the class on IMR and is certified to teach an IMR class and track the results. The expectation is that the individuals will go back to their sites and train other staff and individuals in IMR. Additional funding is currently being sought to provide for training opportunities in other areas of the state.

For FY06, DMHDD reported only on BRIDGES as meeting criteria for this EBP. Several CMHAs complained that they also had IMR activities that met the fidelity requirements. Others have developed IMR curricula as a result of the training described above. Specific IMR curricula may differ slightly, but all include education on mental illnesses, recovery strategies, use of medications and managing side effects, stress management and coping skills. IMR may occur in inpatient and outpatient locations.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Medication management is provided through the TN Medications Algorithm Project (TN MAP). This is a pilot program.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	81	68	68	70	N/A	N/A
Numerator	3,750	5,667	--	--	--	--
Denominator	4,646	8,312	--	--	--	--

Table Descriptors:

Goal: To provide behavioral health services that are rated positively by service recipients.

Target: To attain a minimum rating of 70% of adults who report positively about service outcomes.

Population: Sample of adults receiving public mental health services and taking the adult annual MHSIP survey.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adults submitting a positive survey response on outcomes domain.

Measure: Numerator: Number of positive responses reported in the outcomes domain. Denominator: Total responses reported in the outcome domain.

Sources of Information: DMHDD, Division of Managed Care

Special Issues: The 2006 survey included the “I am neutral” choice, which is thought to have negatively affected response rates for all domains.

Significance: A service system goal is to attain the best possible outcome for the service recipient. Positive perception of care increases the likelihood of continued service acceptance and positive movement toward recovery.

Action Plan: From 2002 till 2004, the MHSIP survey was mailed out to a stratified sample and yielded an averaged 23% response rate. Early percentages for the outcome domain averaged around 65.5%.

In 2005, DMHDD no longer used the mail out method to conduct consumer surveys. A paper survey was given to any willing service recipient with a scheduled appointment at any of twenty-two contract CMHAs within a twenty-day period. This significantly increased both the number of surveys completed and the response rate for 2005. The 2006 survey included the “I am neutral” choice, which is thought to have negatively affected response rates for the five domains (Access, Quality, Outcome, Participation, and General Satisfaction), decreasing the overall average for those domains from 91% to 84%. Future survey results will be reviewed to determine what other factors might have influenced this decrease.

For 2007, the survey was again done by convenience sample during a prescribed period of time. As preparation for making the annual survey a part of the newly developed Tennessee Outcomes Measurement System (TOMS), responses were then rapid data entered directly into the TOMS web site. The regular TOMS consumer outcomes survey includes questions similar to those on the MHSIP in the Outcomes Domain. Responses will be compared to judge the validity of results.

As WRAP and person-centered services become more widely available, consumer perception of the attainment of self-chosen goals will likely play an important role in the tenor of their

responses to questions in this domain.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	.60	1.28	N/A	N/A	N/A	N/A
Numerator	825	1,518	--	--	--	--
Denominator	137,478	118,904	--	--	--	--

Table Descriptors:

Goal: To use TOMS data to determine how many adult service recipients report any work for pay.

Target: To determine a baseline percentage of the number of adult service recipients who are working full or part time.

Population: Adults receiving public mental health services and participating in TOMS

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults reporting at any number of hours worked for pay.

Measure: Numerator: Number of adults employed.
Denominator: Total number of adults receiving community services during FY08.

Sources of Information: TOMS Survey, URS 3a and 4

Special Issues: This indicator was not part of the 2007 application; therefore, no FY07 projection is applicable. Employed is defined as reporting any number of hours worked for pay on TOMS surveys.

Significance: Employment is the number one desire of a majority of consumers who are not employed.

Action Plan: Numerators for FY05 and 06 data were based on annual MHSIP responses. Future data will be based on the TOMS survey, which reports the number of hours during a week that adults either were in school, did volunteer jobs, or worked for pay. TOMS pilot project data for 3,209 adults indicated that 21% reported some work hours for pay, and 33% reported that they were seeking employment. Approximately 8% reported school or volunteer activity.

One of the basics of individual recovery and community integration is employment, if it is desired. It is hoped that DMHDD's Creating Jobs Initiative, promotion of a recovery philosophy in all services, and support of peer employment opportunities will increase the number of adults with SMI who are gainfully employed.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	0	N/A	N/A	N/A	N/A
Numerator	N/A	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To use TOMS data to determine the impact of services on reported criminal justice activity.

Target: To determine a baseline measure of the impact of services on criminal justice involvement.

Population: Adults receiving public mental health services and participating in TOMS.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adults reporting decreased number of arrests.

Measure: Numerator: Number of adults reporting any number of arrests in previous 30 days on initial TOMS survey.
Denominator: Number of adults reporting fewer or no arrests on subsequent 3, 6, or 12 month TOMS surveys.

Sources of Information: TOMS Survey

Special Issues: Not included in 2007 Plan - no projected target. As TOMS is a new system, future performance indicators may be revised.

Significance: Persons with mental illness are best served in the mental health system. One goal of treatment is to reduce the likelihood of behaviors that could lead to criminal justice involvement.

Action Plan: DMHDD has no access to state databases of arrest records of service recipients. Previous negotiations to access were unsuccessful due to reciprocity issues.

The most currently developed question on the MHSIP, using multiple branching, was not added to the 2006 MHSIP. For 2006 URS submission, criminal justice history was obtained through the following question: “In the last year, did you get arrested by police or go to court for something you did?” Approximately 9.3% of adults with participation in services for at least twelve months responded “Yes” to the survey question. For adults receiving services for less than twelve months, the percentage rose to 17.6%.

The TOMS survey, begun in September 2006, is completed four times during the first twelve months of treatment. A summary of pilot project TOMS data reported that 9% of 3,209 TOMS participants reported that they had been arrested at least once within the past month.

DMHDD supports eighteen criminal justice/mental health liaison positions serving twenty-three counties. Liaison staff provide interventions for adults with mental illness or COD who are in jail or at risk of being jailed and promotes collaborative educational efforts between Criminal Justice and Mental Health systems. Staff develop diversion programs, assess jailed adults for SMI/COD, and facilitate in-jail treatment and post-sentence community referral and follow-up.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	12.42	5.56	N/A	N/A	N/A	N/A
Numerator	579	445	--	--	--	--
Denominator	4,660	8,009	--	--	--	--

Table Descriptors:

Goal: To determine how many adults receiving services report homelessness.

Target: Baseline percent via TOMS survey data.

Population: Adults receiving public mental health services and participating in TOMS

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adults surveyed reporting homelessness.

Measure: Numerator: Number indicating a homeless choice as their living situation.
Denominator: Total number of adults completing living situation question on TOMS.

Sources of Information: TOMS Survey, URS able 15

Special Issues: Not included in 2007 plan – no FY07 projection. Survey choices reported as homeless include shelter, on street, outside, or in a vehicle.

Significance: A goal of homeless outreach is to engage persons in the recovery process by enabling access to services including access to stable housing options.

Action Plan: Data from URS Table 15 for both FY05 and FY06 were derived from the annual MHSIP survey. In both years, approximately 75% of surveys indicating a 'homeless' living situation represented adult service recipients.

For the FY07 URS submission, data will be collected from all TOMS surveys done during the fiscal year for comparison with the MHSIP data. In the TOMS pilot survey summary, 2% of 3,209 adult service recipients reported a homeless living situation.

As TOMS is expanded to all CMHAs and more publicly funded individuals, these numbers will increase and be more inclusive. We will use FY08 as a baseline year to determine a more reliable number of persons served and to develop future measures.

DMHDD supports homeless outreach service initiatives across the state for adults through PATH projects.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	69.36	69	70	N/A	N/A
Numerator	N/A	5,764	--	--	--	--
Denominator	N/A	8,310	--	--	--	--

Table Descriptors:

Goal: To empower consumers to develop positive support systems.

Target: To attain a minimum rating of 70% positive response to Social Connectness (SC)Domain.

Population: Adults receiving public mental health services taking the adult annual MHSIP survey.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adults submitting a positive survey response on SC domain.

Measure: Numerator: Number of positive responses reported on the SC domain.
Denominator: Total responses received on the SC domain.

Sources of Information: MHSIP Survey

Special Issues: This domain was not included on state FY05 MHSIP survey.

Significance: Recovery and community integration can be measured by normal relationships and activities within the community as a whole.

Action Plan: The domain for social connectedness was added to the TN annual survey in 2006. As narrated throughout this plan, DMHDD supports a variety of services and supports to increase the social connectedness of consumers and families beyond the provider community.

The regular TOMS consumer outcomes survey includes questions similar to those on the MHSIP in the Social Connectedness Domain. Responses will be compared to judge the validity of results.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	68.18	68	70	N/A	N/A
Numerator	N/A	5,667	--	--	--	--
Denominator	N/A	8,312	--	--	--	--

Table Descriptors:

Goal: To provide behavioral health services that improve everyday functioning of service recipients.

Target: To attain a minimum rating of 70% of adults who report positively on the Level of Functioning domain.

Population: Adults receiving public mental health services taking the adult annual MHSIP survey.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of adults submitting a positive survey response on level of functioning domain questions.

Measure: Numerator: Number of positive responses reported on the functioning domain.
Denominator: Total responses received on the functioning domain.

Sources of Information: MHSIP Survey, URS Table 11

Special Issues: This domain was not included on the state FY05 MHSIP survey.

Significance: The ability to function satisfactorily in major life roles is necessary to achieve recovery goals.

Action Plan: Persons with a mental illness want and need what everybody wants and needs - friends, families, a good education, a good job, and things to do for fun and relaxation. The successful attainment of any of these simple goals can be negatively influenced by symptoms, side effects, behaviors, or frequent hospitalizations.

A combination of effective clinical care, illness management education, and peer and family support contributes to personal growth and successful community integration. The regular TOMS consumer outcomes survey includes questions similar to those on the MHSIP in the Functioning Domain. Responses will be compared to judge the validity of results.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Increased Housing Options

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	1,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To create and expand affordable, safe, permanent and quality housing options in local communities for people with mental illness in Tennessee.

Target: To create 1,000 new housing options during FY08.

Population: Adults with disabilities, especially those with SMI and COD.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Reported number of housing options developed during FY08.

Measure: Number

Sources of Information: CHI Annual Report

Special Issues: Housing options are along a continuum from supervisory group living to home ownership.

Significance: The ability to access housing of choice is a basic need and desire of all persons and can be especially significant to persons with mental illnesses who are working toward recovery.

Action Plan: In 2001, DMHDD formed a strategic plan to partner with Tennessee communities to create housing options for people with mental illness and co-occurring disorders efficiently and effectively. The Creating Homes Initiative (CHI), working with local community housing developers and other stakeholders in partnership with seven regional housing facilitators, has been extremely successful in leveraging a relatively small amount of state dollars to affect housing development.

After surpassing original goals of creating 2,005 new or improved permanent housing options for persons with mental illnesses and co-occurring disorders by the year 2005 and 4,010 by 2005, an ongoing goal was established to create 1,100 new or improved permanent housing options each year.

Since its inception, CHI efforts have leveraged more than $152 million in federal, state, local, public, private, traditional and non-traditional funding sources and successfully created more than 5,700 permanent, safe, affordable, quality housing options statewide. CHI has expanded options from supervised group living to home ownership, striving to develop the kinds of housing needed and wanted by consumers.

Regional housing facilitators work in each of the seven mental health planning regions to develop housing and support resources, fight discrimination in housing, and work with consumers to assess employment and transportation needs. Office of Housing staff also maintain a web site for consumers, family members and providers to search available housing options by type and location. The site offers descriptions of housing options and provides information about the responsibilities and support available for each type of housing option. (www.housingwithinreach.org)

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Services to Older Adults

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	388	500	500	600	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To engage older adults with mental health or substance abuse issues in a treatment/support community.

Target: To provide services to an additional 100 older adults.

Population: Adults age 55 and Over with mental illness or COD.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number engaged in treatment/support services.

Measure: Number

Sources of Information: Annual Project Reports

Special Issues: Data will include numbers served by four Older Adult Outreach Projects and by the OATS project for older adults with substance abuse issues.

Significance: Older adults are less likely to seek mental health or substance abuse treatment through the traditional mental health service system and are best engaged through collaboration with primary care and other older adult non-treatment service communities.

Action Plan: DMHDD recognizes that older adults are underserved within the behavioral health system and promotes projects and outreach activities to better serve them. Four projects provide outreach, screening, assessment, linkage, treatment and supportive services to persons age 55 and over with mental health service needs. These projects also provide community mental health education to promote awareness and knowledge about geriatric mental health concerns. Topics may include signs of misuse and abuse of substances including over the counter medications; signs of dementia, depression, anxiety, and paranoia; signs of elder abuse, and techniques for dealing with disruptive and aggressive behaviors. More general topics related to life experiences of older adults such as grief and loss, loneliness, stress management, and coping with change may also be presented.

The Older Adult Treatment Services (OATS) Program is a CSAT Grant project that is patterned according to Treatment Improvement Protocol (TIP) #26, Substance Abuse Among Older Adults, a best practice guideline for the treatment of substance abuse provided by SAMHSA's Center for Substance Abuse Treatment. This TIP offers guidance on identifying, screening, and assessing not only substance abuse, but also disorders such as dementia and delirium that can mask or mimic an alcohol or prescription drug problem.

Services are to be provided through a team concept. The OATS team positions include a Team Coordinator, Outpatient Therapist, In-Home Therapist, Psychiatrist, Nurse Practitioner, Registered Nurse, Case Managers (2), Clinical Assistant, and a Research Associate. The program will be offered in the Nashville area.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: SMI Priority Population Access

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	91,254	89,113	90,113	90,413	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To ensure access to necessary mental health services for adults with SMI within the public mental health system.

Target: To increase by 300 the number of adults with SMI served.

Population: Adults assessed as SMI and receiving any publicly funded behavioral health services.

Criterion: 2:Mental Health System Data Epidemiology

Indicator: Number of adults with SMI served by age, gender and race/ethnicity.

Measure: Number

Sources of Information: Source: DMHDD, Division of Managed Care
DMHDD, Office of MHSN Services

Special Issues: Decrease in FY06 is due to TennCare reform and the disenrollment of the waiver population.

Significance: TennCare reform resulted in smaller numbers of persons eligible for services under that program. A proportion of disenrollees with SMI are served through the MHSN program.

Action Plan: The population for this performance indicator was expanded last year to include adults with SMI receiving any publicly funded behavioral health service to include both the TCPP and the MHSN. The majority of adults with SMI receive treatment services as enrollees in TennCare. Priority population adults consistently comprise approximately 10% of the total TennCare population, but accounted for 73% of behavioral health service recipients within TennCare in FY06. From FY05 to FY06, the number of adults with SMI served through the TCPP decreased by nearly 16%. MHSN services made up for 85% of that lost service capacity.

Service access for non-TennCare adults with SMI in need of treatment is expedited under a “state only” category pending Medicaid eligibility determination and a “judicial” category for court-ordered services. Since FY06, any TennCare disenrolled adult assessed as SMI is eligible to receive services through the MHSN.

Determining factors for service access include the status of state only and judicial category funding, the success of safety net registration efforts and the impact of Cover Tennessee efforts to provide health care coverage to the uninsured.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Satisfaction with Housing

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	.72	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To use TOMS data to determine service recipients satisfaction with their living situation.

Target: To determine a baseline for the number of adult service recipients who like their living situation.

Population: Adults receiving public mental health services and participating in TOMS.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults responding positively on TOMS survey question.

Measure: Numerator: Number of adults choosing favorable response to "I like my living situation" on TOMS surveys.
Denominator: Total number of adults completing this question on TOMS surveys.

Sources of Information: TOMS Survey

Special Issues: As TOMS is a new system, future performance indicators may be revised.

Significance: While housing must be appropriate to the needs of the individual, consumer choice and satisfaction are key to stability and recovery.

Action Plan: In the TOMS pilot project data summary, approximately 92% of service recipients reported their living situation as 'private residence'. It was noted that 30% of respondents marked 'never' or 'rarely' in response to the statement: "I like my living situation." Additionally, a significant percent reported that they either had something stolen from them or had been hurt physically in the past thirty days.

A longitudinal study of 205 adults assisted in obtaining unrestricted housing through CHI was completed under the Housing Within Reach grant and reported in August 2006. Three areas of evaluation were explored:
1) Does initial access to less restrictive housing predict satisfaction with community-based living arrangements?
2) Is initial satisfaction with living situation associated with housing stability over the subsequent six and twelve months?
3) Does initial access to less restrictive housing predict future housing stability?

The following summary was included in the report.

"Residential stability is desirable, yet housing situations that promote stability are not always the most satisfactory for consumers. Living in independent housing, while more satisfying, may also result in few social contacts and the potential for isolation. These findings suggest that a wide range of housing options is necessary for consumers to be able to find the right balance between independence, healthy interdependence, satisfaction and stability… Lastly, the rate of trauma emphasized once more the need for "safe" places in which people with serious mental illnesses may live and prosper."

For FY08, we have chosen to measure stability in housing as the percent of persons responding positively to the question “I like my living situation”; that is, choosing answers of ‘sometimes’, ‘often’, or ‘almost always’.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Support for Recovery Oriented Services

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	54.70	54.60	50	50	N/A	N/A
Numerator	4,227,300	4,179,500	--	--	--	--
Denominator	7,730,700	7,647,500	--	--	--	--

Table Descriptors:

Goal: To assure availability of support and recovery-oriented services for adults with SMI.

Target: To expend a minimum of 50% of Block Grant funding for recovery-oriented services for adults with SMI.

Population: Adults with SMI.

Criterion: 5:Management Systems

Indicator: Percent of block grant funds allocated for recovery-oriented services.

Measure: Numerator: Amount of Block Grant dollars spent on recovery-oriented services Denominator: Total amount of Block Grant funding minus administrative costs

Sources of Information: DMHDD Budget

Special Issues: Allocations based on continued ability to expend Block Grant funding for non-treatment services.

Significance: Especially in light of loss and reduction of health care benefits, recovery-focused activities provide peer counseling and support, illness management education and help with daily skill building.

Action Plan: Non-clinical services, especially recovery and support services are considered important for maintaining wellness, promoting empowerment, improving community reintegration and contributing to improvement in an individual's quality of life.

Since 1996, DMHDD has utilized Block Grant dollars to pilot, promote, maintain and enhance a variety of service initiatives and alternatives to assist consumers to live, work, learn, and participate fully in their communities despite their illness.

Proposed allocations include projects in consumer support and educational activities, including BRIDGES, and consumer run Peer Support Centers. Each of these service projects features mentoring, educational courses, and peer counseling activities to aid each consumer to recover to the best of his or her ability.

Tennessee

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

Establishment of System of Care (Also see Adult Plan)

In addition to statute cited under a) Adult Plan, Establishment of System of Care, Title 33, Chapter 2, 105 states:

The department shall establish areas for planning and resource allocation. The department shall define geographically dispersed and accessible points of access to service systems and designate providers or mechanisms to provide information and referral for services and supports and for eligibility decisions.

Capitation payments for managed care services and DMHDD grant funding is allocated to community mental health providers to provide services to children and youth within their respective geographic service areas. However, CMHAs may additionally provide services through satellite offices in other regions and persons with health care coverage may seek services from providers of their choice.

Tennessee

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

1) Current Activities – Children and Youth Plan – Available Services

i. Criterion 1 A Comprehensive Community-Based System of Care

Mental Health Services: Access to any TennCare Partners service is accomplished by meeting the medically necessary criteria for that service or being referred through EPSDT screening services. Benefits include:

- Inpatient Psychiatric Treatment
- Outpatient Mental Health Services
- Inpatient/Residential and Outpatient Substance Abuse Treatment Services
- Pharmacy and Laboratory Services
- Transportation to covered services as medically necessary for enrollees lacking
- accessible transportation
- Mental Health Case Management
- 24-Hour Residential Treatment
- Specialized Outpatient and Symptom management
- Specialized Crisis Services and Respite

In addition to the TennCare medical and behavioral health benefit package, the following services are available within the comprehensive array of community services:

Health – Public Health
Tennessee has made a commitment to promoting good health in children from birth until age 21. TENNderCARE is a full program of check ups and health care services for children enrolled in TennCare. These services assure that babies, children, teens and young adults receive the health care they need. (www.state.tn.us/tenncare/child.html) All contracted mental health services promote and provide referral for these early and periodic screening services. Primary care practitioners and pediatricians are educated about physical and emotional developmental benchmarks.

Vaccines and immunization services for children are available through ninety-five county and metropolitan health clinics in Tennessee and at over 1,500 physicians' offices in Tennessee. Free vaccines may be given to children who are enrolled in TennCare, are uninsured, or are of American Indian or Alaskan Native ethnicity.
Children who are insured, but whose health insurance does not cover immunizations, can also get free vaccinations at federally qualified health centers, rural health centers, or local health departments.

Tennessee has a comprehensive genetics program that provides access to newborn screening for genetic/metabolic disorders and newborn hearing screening for early detection of hearing loss.

Rehabilitation Services:
There are no specified rehabilitation services programs for children and youth. However, rehabilitative activities occur within a number of day treatment, respite, educational, residential, and transitional programs. Transitional age youth are encouraged to participate in psychosocial rehabilitation center and peer support center activities. More focused rehabilitation services for youth are described in the Transitional Services section in Criterion 3.

Employment Services: The Department of Education requires transition plans to be included in the Individual Education Plans of all children in special education who are fourteen years or older. This includes the assessment of vocational alternatives. The Division of Rehabilitation Services provides transition-from-school-to-work case managers within the schools and designates Rehabilitation Counselors to work with a school. In 2004, approximately 3% of special education students had a diagnosed emotional disturbance. Employment planning and assistance is also part of the Youth Villages Transitional Living Program described in Criterion 3.

Residential Treatment Services: The DCS provides community-based, twenty-four hour residential treatment for a specialized sub-population of children and youth with SED. DCS also supports regular foster care and therapeutic foster care programs. DMHDD licenses sixty-four residential treatment facilities for children and youth across the state.

Housing Services: DMHDD supports the Creating Homes Initiative (CHI) that leverages funding and promotes collaboration for development of a continuum of housing options for persons with disabilities, including families with children. Independent Living Assistance provides priority population consumers initial and supplemental utility and rent deposits to enable individuals and families maintain housing of their choice. CHI staff are collaborating with DCS to develop supported housing options for youth aging out of state custody.

Educational Services: Day treatment services are funded for children and youth with SED through the TCPP. DMHDD has recommended school-based day treatment to be the preferred model for delivering this service. Non-school-based day treatment programs, which provide education as a component of the program, must qualify as approved schools per DOE policies and procedures.

Tennessee designates lottery revenues to education: from pre-school to college scholarships. Pre-kindergarten programs, with first priority to at-risk four-year-olds, provide opportunities to develop school readiness skills. The Lottery Education After-school Program (LEAP) has provided nearly $6.7 million for eighty-eight new after-school programs for at-risk students across the state. Funding for more than 250 new pre-kindergarten classes was included in the State's FY08 budget.

Medical and Dental Services: Primary Care Physician and Specialist Medical Services are available under TennCare. EPSDT assessments are expected for all TennCare enrolled children under twenty-one. Medical and dental services are provided as medically necessary for children and youth eligible for TennCare. Caregivers of children and youth service recipients are encouraged to participate in developmental screening and routine medical and dental care.

Substance Abuse Services: Primary alcohol and drug prevention, education, and treatment services are provided through contract agencies of both the MCCs and the DMHDD DADAS. Initiatives for children include Residential and Day Treatment programs for adolescents, intensive focus prevention programs, the Tennessee Teen Institute and the Faith Initiative, a program that promotes local church involvement in outreach, training, and education services which target pre-adolescent children living in single parent households in inner-city housing developments.

Case Management Services: Mental health case managers serve as the agent for linking, facilitating, and monitoring the receipt of direct services and supports. Mental Health Case Management is a benefit of the TennCare Partners Program. Children and youth are assessed for level one and level two case management services regardless of priority population status. The assessment process provides for measurements of intensity and duration needed and proposed objectives to be met in the service plan. There are documented policies regarding all level one and level two case management caseload capacities and expected consumer outcomes.

Services for Co-occurring Disorders (COD): Children with COD have access to the range of services offered by TennCare and the DADAS. The TCPP has pursued the development of intensive outpatient services for adolescents with COD in targeted deficit areas. There are four specialized programs to serve youth with Substance Abuse and COD serving thirty-one counties.

Services for Special Populations: DMHDD supports the following service initiatives for children and youth with special needs:

- Services for Children and Youth with Dual Diagnosis of SED and Mental Retardation or Developmental Disability: Three projects provide therapeutic foster care, case management, and intensive in-home treatment and support services for dually diagnosed children and youth.

- Services for Children and Youth in the Juvenile Justice System: DMHDD contracts for forensic evaluation and treatment services for youth under Juvenile Court Order. Eight programs for juvenile sex offender assessment and treatment are funded through managed care; four of the eight are intensive outpatient programs.

- Services for Children of Parents with SMI: This is a program to provide education and support for children and youth who have a parent diagnosed with a mental illness through a school-based outreach curriculum, Mental Health 101.

- Services for Children at High Risk for SED: DMHDD block grant funding supports therapeutic interventions for early intervention and prevention services to children at risk of SED or substance abuse who reside at a residential program for addicted mothers in recovery and their children.

Support Services: DMHDD funding supports the following services:

- Tennessee Voices for Children (TVC), the Tennessee affiliate of the Federation of Families for Children's Mental Health, manages a family support group network across the state for families of children with SED, with family groups in each of the three grand regions of the state. TVC provides technical assistance and consultation for the development of these groups, distributes printed materials, refers families to services, and performs parent advocacy and training activities through family outreach specialists.

- Planned Respite Services: A statewide program that provides respite services to families of children identified with SED or dually diagnosed with SED and mental retardation ages two to fifteen.

- Parent/Professional Support Groups: These support groups are facilitated by both a parent of a child with SED and a professional. The member families determine the agenda and hire their own professional co-facilitator. Respite consultants provide short-term respite and work with the family to identify long-range respite resources.

- NAMI is supported to provide “Vision for Tomorrow” and “Beginnings”, mental health curricula including information on diagnosis, treatment, communication, problem solving and advocacy skills for parents, caregivers and service providers of children with SED.

Activities to Reduce Hospitalization

- Pre-screening: A pre-screening evaluation is mandatory for eligibility for emergency involuntary admission to state mental health institutes. A key element of pre-screening is the determination that all available less drastic alternatives to placement in a hospital are unsuitable to meet the needs of the individual experiencing a crisis. Pre-screeners assessing children must meet additional experience criteria related to working with children.

- Mobile Crisis Response Services: A specialized crisis response service is targeted to children and youth for individual and family intervention. Crisis response services are available 24/7 in every county in Tennessee. More than 60% of face-to-face contacts result in diversion from an inpatient setting.

All services under Criterion 1 have been implemented. The focus on building systems of care statewide is expected to increase provider collaboration and positive consumer and family outcomes.

Tennessee

Child - Transformation Efforts and Activities in the State in Criteria 1

Child - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities Related to Criterion 1: (Numbers correspond to goals and recommendations outlined in the President's New Freedom Commission on Mental Health report, Achieving the Promise.)

1.1: Advance a campaign to reduce the stigma of seeking care and a strategy for suicide prevention.

- Contracted through the Mental Health Association, DMHDD supports a statewide education and information program about mental health and mental illness, children and youth with SED, their needs and the needs of their families. Erasing the Stigma and Kids on the Block presentations are made to forums of youth and adults with the goal of promoting knowledge about mental health and reducing stigma.

Events, project goals, and presentations are developed in collaboration with major children's advocacy groups. Thousands of adults and children attend these presentations annually.

- Implemented the Tennessee Lives Count (TLC) grant contract targeted to high-risk youth ages 10-24. A Youth Coordinator and two Youth Trainers will provide training about suicide risk and intervention strategies at conferences and other training forums and assist in the development and distribution of suicide prevention marketing materials.

DMHDD also supports the Jason Foundation youth suicide prevention curriculum in more than 800 middle and high schools across the state as well as churches and other community organizations that work with children.

4.1: Provide prevention and early intervention services and education.
DMHDD promotes prevention and early intervention by assisting with depression and anxiety screenings in local communities and coordinating activities for National Depression Screening Day in downtown Nashville. Information and screening tools are made available at various venues such as the Minority Health Summit and the Women's Fair.

Partnerships with the Bureau of TennCare and other child-serving departments improve access to and quality of prevention and early intervention services for children and youth. DMHDD participates in the annual conference sponsored by the "Yes 2 Kids" organization to provide education to parents, professionals and adolescents about prevention and early intervention services.

5.2: Advance evidenced-based practices using dissemination and demonstration projects.
The system of care model is identified as an emerging best practice in Achieving the Promise and is the least fragmented and most collaborative model of care for children and youth with SED and their families.

A five-year federal system of care grant that ended in August 2006 established an infrastructure for statewide replication. This grant led the way in coordinating resources, providing support to families, involving youth in treatment options and strategizing for replication and sustainability of the model. A system of care model continues under a contract between DCS and TVC. Funding constraints limit service delivery to children in state custody.

The Early Childhood Network is a collaborative effort among local child serving entities in Maury and Rutherford Counties to identify and address the mental health needs of children from preschool through third grade using prevention and early intervention strategies. This effort is intended to provide a seamless and comprehensive system to identify and serve, at an early age, children in need of mental health services by networking all local agencies that work with these children. The Mule Town Family Network, a six-year federal system of care grant awarded in September 2005, builds upon this

coordinated effort of state, county, local agencies, individuals, service recipients and their family members to provide wraparound services for children and youth with SED in Maury County.

Tennessee

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

ii. Criterion 2 Mental Health System Data Epidemiology

Tennessee utilizes the federal definition of SED: Children and adolescents from birth up to age eighteen years who currently have, or at any time during the past year have had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Children and youth are classified by use of a Targeted Population Group (TPG) form. Assessments are done by DMHDD approved raters from authorized CMHAs and RMHIs. The degree of functional impairment is assessed with the Global Assessment of Functioning (GAF). Those meeting the federal definition with a GAF of 50 or below are considered SED and classified as TPG 2.

Estimates of the annual prevalence of SED in Tennessee are taken from the 2005 NRI prevalence table. Due to a high percent of poverty and the fact that data reported will include children and youth from 0-17, the highest federal estimate for the state of 92,330 will be utilized.

In FY06, approximately 57,633 children and youth under age 18 identified as SED were enrolled for some period of time in the public mental health managed care system, approximately 62% of the prevalence rate. Just less than half of that number maintain a current (within one year) assessment of SED. Of that number, 91% received a behavioral health service.

Tennessee

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

In FY06, approximately 57,633 children and youth under age 18 identified as SED were enrolled for some period of time in the public mental health managed care system, approximately 62% of the prevalence rate. Just less than half of that number maintain a current (within one year) assessment of SED. Of that number, 91% received a behavioral health service.

During FY08, DMHDD Block Grant and state funded services are estimated to provide services to over 220,000 children, families, caregivers, and others. Further quantitative goals are included in Children's Section III, Goals, Targets, and Action Plans.

Tennessee

Child - Transformation Efforts and Activities in the State in Criteria 2

Child - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities Related to Criterion 2: (Numbers correspond to goals and recommendations outlined in the President's New Freedom Commission on Mental Health report, Achieving the Promise.)

4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

A sub-group of priority population children and youth are those with a co-occurring disorder of mental illness and substance abuse/dependence. TennCare data from FY06 indicated a slight decrease in the number of persons under age eighteen with a co-occurring diagnoses. Around 80% of children and youth with a COD are receiving substance abuse services.

About 50% of CMHAs have either fully or partially integrated programs for the delivery of behavioral health services. Managed care organizations currently support four programs that serve youth with COD in thirty-one counties.

Tennessee

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

iii. Criterion 3 Children's Services

The system of mental health care for children and youth, including those with SED, consists of three major service delivery entities: TennCare/TennCare Partners; DCS for children in or at risk of state custody; and DMHDD-contracted services and state hospitals.

- DMHDD contracts with managed care organizations to deliver behavioral health care services, including those determined by EPSDT assessment to be medically necessary, for children and youth to age twenty-one enrolled in the TennCare Partners Program. As of April 2007, 592,696 children and youth below the age of eighteen were enrolled in TennCare.

- DCS was created in 1996 to fulfill the state's responsibilities for children committed to, or at risk of commitment to, the state's custody. These custodial duties were previously distributed across the Departments of Mental Health and Mental Retardation, Human Services, Youth Development, and Education. DCS provides necessary services for children who are placed in state custody, or are at risk of placement in state custody.

  As of June 30, 2006, approximately 9,271 children and youth were in legal and physical state custody. Many of these children enter custody due to neglect, abuse, abandonment, delinquency, or are awaiting adoption.

  Almost all custodial children and youth are enrolled in TennCare. The TCPP provides for medically necessary services with the exception of residential treatment services, which are the responsibility of DCS. Mental health case management services for children in state custody with SED can be accessed through the TCPP.

  DCS has specific policies and procedures in place to maintain youth in placements inside Tennessee whenever possible. Out of state placements are tracked through the TCPP contract for both DMHDD and DCS youth. Such placements have been in the single digits for the past three years.

  DMHDD Office of Children's Services staff work closely with DCS to coordinate service and placement needs for children with SED or COD.

- DMHDD, through Block Grant funding and state appropriations, contracts with multiple agencies to deliver education, prevention, early intervention, respite, and outreach mental health services for children and youth with or at risk of SED.

  DMHDD manages children and youth inpatient psychiatric programs that provide acute and extended care in two of the state psychiatric hospitals and contracts for outpatient and inpatient mental health evaluations of children and youth ordered by juvenile courts.

  The DADAS provides for education, early intervention, and non-TennCare-covered substance abuse treatment services for children and youth through state funding and the Substance Abuse Block Grant award.

Tennessee's integrated statewide system of services for children and youth with SED includes social, educational, juvenile justice, substance abuse, and mental health services.

Service integration is accomplished via multiple linkages and interactions between the primary departments of state government that serve youth and their respective networks of provider agencies. The Departments of Health, Education, Children's Services and Mental Health and Developmental Disabilities each have complementary responsibilities for meeting the needs of children and youth.

- Social Services: DMHDD provides consultation to DHS staff on mental health treatment issues, community resources, and referral procedures to utilize in the training of case managers who will work with special needs families participating in Tennessee's welfare to work program, Families First.

- Educational Services: The DOE approves the special education annual plans of all schools operated by DMHDD and DCS. Staff from each department participates in common projects (e.g. Dropout prevention, Family Resource Centers). In addition, DMHDD has an extensive presence in school systems with the Jason Foundation curriculum and, particularly, in rural areas with Project BASIC. (See service descriptions in Children's Services Criterion 5.)

- Juvenile Justice Services: DMHDD contracts for both inpatient and outpatient court-ordered evaluations and mental health services for children and youth committed by the juvenile court. DMHDD Office of Forensic and Juvenile Court Services staff monitor all evaluations and assist in accessing recommended treatment services as necessary.

  A point-in-time survey of forty juvenile justice facilities, reported in 2004, indicated that nearly half of the juveniles had a mental health or substance abuse problem, with 30% having both. Based on needs identified in the survey, a Juvenile Justice Workgroup of the Criminal Justice Committee worked with various state and judicial entities to develop a screening process to be used at the earliest possible contact point with the juvenile justice system, so that behavioral health problems could be detected and treated early. A recommendation to use the GAIN-SS (Global Assessment of Individual Needs, Short Screen) has not yet been implemented.

- Substance Abuse Services: The DADAS provides a number of prevention programs for children, including intensive focus groups, the Tennessee Teen Institute, and The Faith Initiative, targeting pre-adolescent children living in single parent households in inner-city housing developments.

  Treatment services are primarily targeted to persons with no other means of paying for treatment. Funding is required to serve special needs populations such as pregnant women, women with dependent children, adolescents, and persons of any age at risk for or infected with HIV.

- IDEA Services: PL 105-17, the Individuals with Disability Education Act is administered by the DOE. Services and activities developed under Tennessee's Part C process include: an 800 telephone number information and referral line, a directory of services available in each area of the state, child-find activities, community awareness activities, and contracted mental health case management services. All children included in Part C have an Individualized Family Service Plan, which details needed services. An Interagency Coordinating Council meets regularly to guide these activities and to develop and monitor the State's Plan for Part C. Disabilities that can be served under Part C include social and emotional delay.

Special education and needed related services for children and youth with SED are specified in an Individual Education Plan and provided by the local education agencies, the DCS contract provider or facility school for children in state custody, or schools operated by DMHDD for children and youth in RMHIs. An interagency agreement defines the fiscal responsibilities for special education related services between DOE and the TennCare.

- Transitional Services: Coordinated service and life planning for youth transitioning into adulthood are necessary components of a comprehensive behavioral health system and must be tailored to the unique needs of this population. Many of the system barriers to continuity between youth and adulthood have been identified through efforts by advocates and providers. These efforts have culminated in the development of a statewide task force for transitional services development.

  Youth Villages, has a model Transitional Living Program to help youth between the ages of 18 and 21 get a good start on adulthood. Counselors help young people learn how to problem solve, find housing and health services, access transportation and meet basic needs. Counselors teach life skills like budgeting, menu planning and grocery shopping. They help young people learn the skills needed to find and keep jobs and, when appropriate, help them reunite with their families.

  Young people in the Transitional Living program set education and career goals. For some this means obtaining a GED or high school diploma. For others it means applying for college scholarships or attending vocational training. Staff provides assistance with selecting a career, developing a resume, applying for jobs, and preparing for job interviews. A Transitional Specialist may also help a young person learn to get along with co-workers and supervisors in the workplace.

  Staff within the Division of Recovery Services and Planning have been collaborating with DCS on appropriate housing options for children aging out of state custody and preparing to live independently. One CMHA in the Nashville area has purchased property and is pursuing program funding through DCS, DMHDD, and managed care organizations. The program hopes to open in October 2007 to provide housing and transitional services for seventeen youth aging out of state custody, foster care, or being discharged from the RMHI.

Tennessee

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

The department shall establish areas for planning and resource allocation. The department shall define geographically dispersed and accessible points of access to service systems and designate providers or mechanisms to provide information and referral for services and supports and for eligibility decisions.

Capitation payments for managed care services and DMHDD grant funding is allocated to community mental health providers to provide services to children and youth within their respective geographic service areas. However, CMHAs may additionally provide services through satellite offices in other regions and persons with health care coverage may seek services from providers of their choice.

Tennessee

Child - Transformation Efforts and Activities in the State in Criteria 3

Child - Describes mental health transformation efforts and activities in the State in Criteria 3, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities Related to Criterion 3: (Numbers correspond to goals and recommendations outlined in the President's New Freedom Commission on Mental Health report, Achieving the Promise.)

2.2: Involve consumers and families fully in orienting the mental health system toward recovery.

- Activities being undertaken through SJR799 by the Select Committee on Children and Youth: hearings, community meetings, and surveys, are involving youth, families and other caregivers in the design process of a reformed children's mental health system.

- DMHDD contracted with TVC to provide one or more Parent Leadership Academies. The academies include parent training to enhance advocacy skills, improve ability to navigate the child service system and increase awareness of mental health issues for youth. The training will provide information to families of children and youth with serious emotional disturbance to give families increased ability to network with child serving agencies.

- DMHDD has increased the participation of caregivers of children with SED on its state and regional planning councils, including a youth representative. The TVC Youth Council is especially active in anti-stigma and advocacy efforts for adolescents with mental illness or emotional disturbance.

4.1: Promote the mental health of young children.
DMHDD promotes the mental health of young children through a variety of grant programs of early screening, intervention and referral services. DMHDD has partnered with the Bureau of TennCare and other child-serving departments to improve access to and quality of prevention and early intervention services and participates in "Yes 2 Kids" activities that provide education to parents, professionals, and adolescents about prevention and early intervention services.

TENNderCARE, the program of check ups and health care services for children and youth up to age twenty-one who have TennCare are the initial step in identifying children with needs requiring more in-depth testing and diagnostic procedures. Screenings are provided to initially identify problems in a general area requiring further assessment or evaluation, including behavioral and developmental assessments, while diagnostic procedures seek to identify or rule out specific problems such as ADHD or mental retardation. Screening instruments are designed for use with all children during well-child visits.

Tennessee

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

Homeless

The TCPP provides a continuum of services for all eligible children with SED. Homeless persons who meet the eligibility criteria may receive TennCare using agency addresses, shelter addresses, or Post Office boxes. Homeless children and youth who are not TennCare eligible have access to crisis response and intervention services statewide and may participate in no-cost family support groups.

DMHDD funds outreach case management services for homeless children and youth with SED, or at risk of SED, in the Nashville/Davidson County area, the Johnson City area, and in the cities of Chattanooga, Knoxville, Jackson, and Memphis.

Homeless Outreach staff assist in identifying children and youth with SED or who may be at risk of SED. Staff assist the parent(s) in securing needed mental health services for their children and link them with other services needed to keep the family intact and healthy. Outreach staff also refer children for EPSDT screening, which often is the first contact with medical services since birth.

The homeless outreach worker functions as a liaison between the school and the family, facilitates mental health evaluation and treatment, and assists the family in securing more permanent housing. Staff provide assistance until the family becomes linked with more durable, on-going case management, treatment, and social service agencies, is no longer homeless, or no longer accepts services.

Each program has access to flex-funds to purchase a variety of goods and services that are not otherwise funded such as emergency housing, respite, therapeutic summer camp, clothing, school supplies, transportation, and emergency child care.

There are three housing programs funded through the federal McKinney Act Permanent Housing for Homeless Program. One site has sixteen apartments dedicated for women with SMI and their children.

Tennessee

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Rural

Tennessee will define a “rural county” as one that has 50% or more of its population in a rural area and is not included in the Metropolitan Statistical Areas list. This information is obtained from the 2003 Tennessee Statistical Abstract. Using this definition, there are fifty-nine rural counties in Tennessee.

TCPP provides a comprehensive continuum of services ranging from acute inpatient care to case management for eligible populations, and policies require equal eligibility, service coverage, and availability statewide. For the past three fiscal years, approximately 25% of the total number of children and youth enrolled in TennCare and assessed as SED resided in a rural county. The number of rural children and youth served, as a percent of the total number of children and youth served, increased from 23.9% in FY05 to 26.9% in FY07.

Tennessee augments traditional clinical services with alternative services designed to decrease discrimination, engage rural families, and provide opportunities for education and support in areas where there are few community resources.

o A majority of Project BASIC sites are in high-risk, rural areas of the state and are a partnership between a local school and the local CMHC.

o DMHDD involves individuals from rural Tennessee in the planning process and has ensured that there is representation from families, consumers, providers and other advocates from rural areas on all state and regional councils. The Department provides travel and childcare reimbursement to consumers and family members in an effort to encourage participation.

o The Department’s Family Support and Advocacy Program, implemented by the TVC, operates statewide and has successfully provided community education in rural areas of the state, based on needs assessment surveys of the community.

o The Mental Health Association of Middle Tennessee, in conjunction with Tennessee Rotary Clubs, sponsors “Erase the Stigma” presentations statewide to school, civic, and community groups. Fifty percent (50%) of presentations are required to be in rural counties.

Tennessee

Child - Transformation Efforts and Activities in the State in Criteria 4

Child - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

Transformation Activities Related to Criterion 4: (Numbers correspond to goals and recommendations outlined in the President's New Freedom Commission on Mental Health report, Achieving the Promise.)

3.2: Improve Access to Quality Care in Rural and Geographically Remote Areas.
DMHDD involves individuals from rural Tennessee in the planning process and ensures representation from families, consumers, providers and other advocates from rural areas on all state and regional councils. The Department provides travel and childcare reimbursement to consumers and family members in an effort to facilitate participation.

As stated in the Criterion 4 narrative, DMHDD requires rural program access for several contracted service initiatives. MCC provider networks are monitored by Division of Managed Care staff to review the adequacy of rural provider availability and negotiate corrective action plans as needed.

Tennessee

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

v. Criterion 5 Management Systems

Resources for Providers

Tennessee made available $406,235,800 in capitation payments made monthly to the BHOs for services provided to TennCare Partners Program enrollees through June 30, 2007.

The State continued the financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees that it assumed in 1999. The pharmacy cost for individuals for FY06 in the community amounted to $213,581,629 with medications for individuals during inpatient stays included in the inpatient rates received by the respective inpatient facilities.

The cost of providing forensic and court-ordered evaluations performed at the five RMHIs and in the community is estimated at $28,071,450.

DMHDD funded community mental health services, excluding forensic and court ordered evaluations, at $41,878,782. This funding includes the CMHS Block Grant award and other federal grants received by the DMHDD.

Further, the five RMHIs expended $94,903,863 above revenue received to provide inpatient mental health services.

In total, roughly $784,671,524 was directed for the provision of mental health services to individuals within Tennessee for FY07.

DMHDD enters into grant agreements to provide a Clinical, Therapeutic and Recovery Services package for priority population adults who lost TennCare benefits, and contracts for other service initiatives outside the scope of services provided under the TCPP. Funds are administered through individual grants with CMHAs and other agencies, various Delegated Purchase Authorities for specific services, and additional interdepartmental funds made available to supplement federal grants awarded to Tennessee.

Staffing

DMHDD employs approximately 2,900 staff; some 2,600 in the five state psychiatric hospitals and the remainder in the Central Office.

State contracts with the managed care organizations require those entities to maintain an adequate network to provide behavioral health services to persons covered under the benefit plan. The managed behavioral health care outpatient network consists of around 1,200 credentialed and contracted individual and group providers, exclusive of individual CMHA staff.

Additional resources for children and youth include:
18 providers of 24-hour residential treatment at 23 locations
15 providers of inpatient psychiatric services at 16 locations
16 providers of inpatient substance abuse services at 18 locations
1 provider of crisis response services for 95 counties

Training

MCC consumer advisory staff provide on-going training and information sessions to inform providers, consumers, family members, and advocates about Tennessee's managed care system.

In order to improve and build upon the skills of providers delivering mental health services, TennCare requires MCCs to offer the following:

1. an educational plan for providers formulated with input from the MCC Avisory Board; (Boards must have minimum 51% family and consumer membership and consumers and family members must be included as trainers.)
2. cross-training of mental health and substance abuse providers;
3. mental health training for primary care providers; and
4. assurance that providers are appropriately licensed, certified, accredited, approved and/or meet DMHDD standards, whichever is appropriate.

In addition to routine networking opportunities, monitoring and technical assistance, DMHDD provides a variety of training related to implementation of grant-funded services to community providers, family and consumer groups and special grant recipients.

- The Regional Intervention Programs (RIP) provide training as an essential element of the model - parent training of behavior management. Statewide training is provided to new resource coordinators at the Nashville location. RIP staff and statewide RIP technical assistance staff conduct training.

- Project BASIC staff receive intensive training at initial implementation and as staff turnover occurs. Technical assistance is available on request and is provided during site visits.

- The Tennessee Respite Network training curriculum for respite providers is offered several times per year or as requested. The network maintains specialized training curricula for problem issues. DMHDD participates in sponsoring an annual Tennessee Respite Conference.

DMHDD staff overseeing service contracts for children and youth provide regularly scheduled training for program staff and many projects provide additional provider and community training and educational events.

Tennessee

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

Training Providers of Emergency Health Services (Also See Adult Section)

MCC provider training and DMHDD all-hazards response training includes education about specific responses and interventions for children and adolescents. These include school-based crisis intervention, childhood trauma, intervention with families and suicide prevention and intervention.

DMHDD continues its collaboration with DCS and TVC on the development of a trauma counseling training program for counselors working with victims of child abuse or other traumatic events.

Tennessee

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Expenditure of 2008 Block Grant Allocation

The 2008 Block Grant projected allocations are based on the final 2007 award amount of $7,896,737 for Tennessee. Ninety-five percent (95%) of the total award will be granted to community based programs in accordance with the expectations of the block grant. Approximately 5% of the award, or $394,836, supports administrative functions relative to the community mental health system and Mental Health Planning and Policy Councils' support and activities. Despite recent decreases in the Block Grant award, DMHDD has not decreased program allocations, utilizing an early withdrawal of the next year's Block Grant award as necessary. (See Table B.)

DMHDD utilizes its Block Grant funding to provide community mental health services designed to promote education, prevention, and early intervention and build a reliable community support service system that emphasizes youth empowerment and resiliency, and family education and support.

Currently, eleven private not-for-profit CMHCs and six other community agencies receive federal mental health block grant funds to provide these services. Each contracted agency must provide services in accordance with a specific contract, budget, and scope of services. (Contract agencies may change or others may be added as service contracts are finalized.)

Some $2,484,200 in CMHS Block Grant funding will be allocated for children and youth services in accordance with Criterion 1-5 in the following manner:

BASIC **$ 1,600,500**

Project BASIC (Better Attitudes and Skills in Children) is a school-based mental health early intervention and prevention service that works with children from kindergarten through third grade. Goals are to enhance awareness and capacity for response of school personnel to the mental health needs of children and to reduce the incidence of adolescent and adult mental health problems. Children with SED are identified and referred for mental health services. Funds support BASIC programs at forty-seven elementary school locations.

Planned Respite Services **$ 586,700**

This is a program that provides respite services to families of children identified with serious emotional disturbance, or dually diagnosed with SED and mental retardation, who are ages two to fifteen. Respite consultants provide short-term respite and work with the family to identify long-range respite resources. Individualized family respite plans are developed with the family. The consultant enables families to develop community-based respite resources and utilize them effectively.

Funding supports respite services in each of the seven mental health planning regions across the state. Included in the total is $30,000 that supplements state dollars to fund a voucher program to pay for respite services for children ages birth to eighteen of families who reside in Memphis/Shelby County.

Early Childhood Network **$ 145,000**

This is a collaborative effort on the local level to identify and address the mental health needs of preschool through third grade children through prevention and early intervention strategies. The effort is intended to provide a seamless and comprehensive system to identify and serve, at an early age, children in need of mental health services by networking all local agencies that work with this age group.

Funding supports projects in two counties that currently have RIP, BASIC, and Day Care Consultation and have identified gaps in services.

Jason Foundation School Curriculum $ 77,500
In response to the Surgeon General's Call to Action to Prevent Suicide Plan, one of Tennessee's strategies targets providing educational programs for youth that address suicide. The Jason Foundation offers a Triangle of Prevention approach for awareness and prevention of youth suicide. The project addresses youth, parents, teachers, and educators from middle school to college in suicide awareness and prevention through educational programs and seminars.

NAMI-TN Parent Education $ 47,500
"Visions for Tomorrow" and "Beginnings" are programs that provide education for families of children with SED, utilizing a train-the-trainer model. The goal of the program is to empower parents and guardians to become advocates for their children and to develop tools to help other families in a supportive, educational manner.

Suicide Prevention $ 18,000
Funds supplement state dollars to support the Tennessee Suicide Prevention Network (TSPN), a statewide coalition that developed and now oversees the implementation of strategies to eliminate/reduce the incidence of suicide across the life span, to reduce the stigma associated with suicide, and educate communities throughout the state about suicide prevention and intervention.

Renewal House $ 4,000
Funding supplements other state dollars to support early intervention and prevention services to children at risk of SED or substance abuse who reside at Renewal House, a residential program for addicted mothers in recovery and their children. Services provide on-site child, family and group counseling for which there is no third-party payer source. Parenting classes, support groups and family enrichment are provided for family preservation. Therapeutic services are also provided for children when evaluations deem such services appropriate.

Cultural Competency $ 5,000
Cultural and Linguistic competency promotion is targeted for mental health agencies, mental health providers and mental health interpreters.

Table B details the proposed 2008 Block Grant for children and youth services by agency and program.

Table B. 2008 BLOCK GRANT FUNDS FOR CHILDREN AND YOUTH SERVICES

PROJECTED ALLOCATION DATE JULY 1, 2008

CMHC	BASIC	Renewal Hs/ Cult. Comp.	Early Childhood Network	Jason/ NAMI/ TSPN	Planned Respite	Total
Frontier	281,557	0	0	0	81,112	$362,669
Cherokee	70,028	0	0	0	0	$70,028
Ridgeview	40,016	0	0	0	48,112	$88,128
Volunteer	280,110	0	72,500	0	184,040	$536,650
Fortwood	40,016	0	0	0	0	$40,016
Centerstone	263,887	0	72,500	0	81,112	$417,499
Carey	120,048	0	0	0	0	$120,048
Pathways	120,047	0	0	0	0	$120,047
Quinco	224,727	0	0	0	81,112	$305,839
Professional Counseling	160,064	0	0	0	0	$160,064
Frayser	0	0	0	0	81,112	$81,112
OTHER AGENCY						
TN Respite Coalition	0	0	0	0	30,100	$30,100
Renewal House	0	4,000	0	0	0	$4,000
Jason Foundation	0	0	0	77,500	0	$77,500
MHA of Mid TN	0	(CC) 5,000	0	18,000	0	$23,000
NAMI-TN	0	0	0	47,500	0	$47,500
Total C&Y	**$1,600,500**	**$ 9,000**	**$ 145,000**	**$143,000**	**$ 586,700**	**$ 2,484,200**
Total Adult						$ 5,167,300
Total Both						**$ 7,651,500**
Admin. 5%						$394,836
[a] Total Allocation						**$ 8,046,336**

[a] Total allocation exceeds amount of 2007 Block Grant Award ($7,896,737). The shortfall is expected to be accommodated by early expenditure from the anticipated 2009 Block Grant allocation.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	50,408	48,526	49,526	49,726	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To maintain access to behavioral health services through the public managed care system for children and youth.

Target: To serve an additional 200 children and youth in FY08.

Population: Children and youth under 18 enrolled in TennCare.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Unduplicated number of C&Y served.

Measure: Number

Sources of Information: DMHDD, Division of Managed Care

Special Issues: As of April 2007, 592,696 children and youth were enrolled in TennCare.

Significance: While more options are becoming available for health insurance coverage to parents and children under the Cover Tennessee initiatives, it is known that a number of children and youth, especially minorities, are either enrolled in TennCare and not accessing services or are eligible for enrollment in TennCare and not pursuing coverage.

Action Plan: TennCare enrollment remains available for children and youth under age 21 who meet eligibility requirements for Medicaid and for other children without access to health insurance that meet other criteria. C&Y benefits have not changed and all services are available without limits as deemed medically necessary or referred by EPSDT screening. The number of children and youth receiving behavioral health care services through TennCare rose an average of 6% a year until FY05. There was a decrease in the number of children and youth served in FY06.

The State estimates that 125,000 children and youth do not have health insurance. Continued local and statewide media efforts are made to increase parent and other caregiver awareness of the opportunities for health insurance coverage for children and youth through TennCare or CoverKids.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	8.80	8	9	9	N/A	N/A
Numerator	36	39	--	--	--	--
Denominator	408	490	--	--	--	--

Table Descriptors:

Goal: To offer effective inpatient treatment and continuity of care to maximize community tenure.

Target: Maintain rate of readmission to state psychiatric hospitals within 30 days of discharge to below 10%.

Population: Persons age 0-17 receiving a psychiatric inpatient service.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of children and youth discharged from inpatient services in FY07 that are readmitted within 30 days.

Measure: Numerator: Number of persons age 0-17 who are readmitted to a state hospital (RMHI) within 30 days of discharge.
Denominator: Number of persons age 0-17 discharged from a state hospital (RMHI) during the previous fiscal year.

Sources of Information: DMHDD, Division of Managed Care, Office of Hospital Services

Special Issues: Only 21% of inpatient psychiatric hospitalization of children is at a state facility.

Significance: Children are best served within the context of family and community

Action Plan: State hospitals accounted for 21% of children and youth admissions in FY06, a slight decrease from FY05. The MCCs contract with RMHIs and private psychiatric hospitals to provide inpatient care to children and youth; only two state psychiatric facilities maintain service programs designed for children and youth.

Readmission rates, at least within 30 days, are often dependent upon continuity of care and connection with community treatment and support services. MCC standards of care require a case management assessment prior to discharge, a case manager face-to-face encounter within seven days, and routine outpatient services available within fourteen days. Outpatient providers are required to maintain access logs of initial appointments and performance is monitored by both the MCC and DMHDD.

It is noted that the readmission rate within 30 days to all psychiatric facilities is only slightly higher than readmission rates to state hospitals.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	16	18.57	16	16	N/A	N/A
Numerator	65	91	--	--	--	--
Denominator	408	490	--	--	--	--

Table Descriptors:

Goal: To assure effective inpatient treatment and continuity of care to maximize community tenure.

Target: To decrease rate of readmission to state psychiatric hospitals within 180 days of discharge to FY05 levels.

Population: Persons age 0-17 receiving a psychiatric inpatient service.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of persons age 0-17 discharged from inpatient services in FY07 that are readmitted within 180 days.

Measure: Numerator: Number of persons age 0-17 who are readmitted to a state hospital (RMHI) within 180 days of discharge.
Denominator: Number of persons age 0-17 discharged from a state hospital (RMHI) during the previous fiscal year.

Sources of Information: DMHDD, Division of Managed Care

Special Issues: Only 21% of inpatient psychiatric hospitalization of children is at a state facility.

Significance: A major goal of a comprehensive, community-based mental health system of care is the development of effective community and in-home alternatives to hospitalization.

Action Plan: While serious emotional disturbances can require hospitalization for necessary adjustments or crisis situations, a major outcome of a comprehensive, community-based mental health system of care is the ability to provide early intervention and family-centered services within the home, school, or other least restrictive environment.

Intensive in-home services for at risk children, education and support for caregivers of children with SED and other emotional and behavioral issues and intensive, specialized interventions by children and youth crisis services programs, all serve to impact the child’s ability to remain in the family and community setting.

It is noted that the readmission rate within 180 days to all psychiatric facilities is significantly higher than readmission rates to state hospitals.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	3	2	3	3	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To promote the use of behavioral health interventions having consistent, scientific evidence showing improved outcomes.

Target: To maintain availability of evidenced-based practices.

Population: Children and Youth

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of SAMHSA recommended evidenced based practices being provided in Tennessee.

Measure: Number

Sources of Information: Provider Survey

Special Issues: States may be providing other best practices that are not included in the URS table listing.

Significance: Evidence-based practices are interventions or treatment approaches that have been scientifically demonstrated to be effective, regardless of the discipline that developed them.

Action Plan: The URS Table 16 list of Evidenced Based Practices for children includes:

1. Therapeutic Foster Care (TFC)
2. Multi-Systemic Therapy (MST)
3. Family Functional Therapy (FFT)

The number of children and youth receiving EBP services is reported by means of an annual provider survey. In FY06, agencies were asked to respond service numbers based only on programs that met minimum fidelity requirements. All services were reported, but are not widespread.

DCS provides foster care services and contracts with area CMHAs to provide specialized training and support services to foster parents who provide TFC services.

Youth Villages, an multi-state service agency for emotionally and behaviorally troubled children and their families, operates in Tennessee and is one of the largest providers of MST and MST-based programs in the world.

The FFT model of care was reported by only one CMHA.

While DMHDD and the MCCs promote the use of evidenced based practices, there are no contractual requirements determining which recognized programs be used.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Therapeutic Foster Care (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	411	838	858	878	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To assure appropriate placement of children with SED or other emotional problems who require foster care.

Target: To increase by 20 the number of children and youth receiving an Therapeutic Foster Care.

Population: Children and youth requiring foster home care provided by DCS during FY08.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children and youth receiving therapeutic foster care during FY08.

Measure: Number

Sources of Information: Source: Provider Survey, DCS

Special Issues: States may be providing other best practices not included in URS Table 16.

Significance: Caregivers providing foster care to children and youth with emotional disturbances or mental illness require training and support to promote a stable, secure, and therapeutic environment.

Action Plan: Families sometimes are unable or unwilling to care for children. DCS is responsible for providing temporary care or foster care for many of these children. DCS recruits foster families who provide safe and supportive homes in which the children's emotional, physical and social needs can be met. Sometimes, specialized training is necessary to provide such care.

TFC is a temporary service until the family and, in some cases, the child can address the problems which made placement necessary. When parents cannot or will not make their home safe for the child's return, other permanent options are sought. These include adoption or, for older youth, independent living arrangements.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Multi-Systemic Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	3,230	1,200	1,200	1,200	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To promote evidenced-based practices that successfully demonstrate positive outcomes.

Target: To maintain MST services to 1,200 children and youth.

Population: C&Y assessed as SED receiving a TennCare Partners service or DCS provided service during FY08.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children and youth receiving MST.

Measure: Number

Sources of Information: DMHDD, Division of Managed Care, Research and Analysis Group

Special Issues: The decrease from FY05 to FY06 is due to minimum fidelity criteria being used to report. Youth Villages is the only community contract agency reporting MST services meeting minimum fidelity criteria.

Significance: States may be providing other best practices that are not included in the URS table listing.

Action Plan: Youth Villages, a multi-state service agency for emotionally and behaviorally troubled children and their families, operates in Tennessee and is one of the largest providers of MST and MST-based programs in the world. Other CMHAs report use of components of MST within their children and youth programs, but do not meet full fidelity criteria for the model.

Statute now prohibits DCS from expending state funds on any juvenile justice program or program related to the prevention, treatment, or care of unruly and delinquent juveniles, including any service model or delivery system, unless the program is evidence-based. This ruling does not mandate MST as that EBP. However, as MST is a national model for services to delinquent children and youth, numbers served through this intervention may increase in the future.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Functional Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: No PI planned for this measure. Available at one CMHA.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	80	66	68	70	N/A	N/A
Numerator	1,147	1,753	--	--	--	--
Denominator	1,435	2,659	--	--	--	--

Table Descriptors:

Goal: To provide behavioral health services to children and youth that produce positive measurable and observable outcomes.

Target: To attain a 70% rating on the number of families who report positively about service outcomes for their children.

Population: C&Y receiving publicly funded services and completing a MHSIP annual survey in FY08.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of persons scoring a positive response on outcomes domain.

Measure: Numerator: Unduplicated # of individuals reporting positive response to questions in outcomes domain.
Denominator: Unduplicated # of individuals responding to domain questions.

Sources of Information: DMHDD, Division of Managed Care MHSIP survey results

Special Issues: Similar questions on the TOMS will be compared for validity.

Significance: An observable improvement provides opportunities for positive feedback to the child and promotes acceptance of treatment for the caregiver.

Action Plan: The highest goal of any service system is to attain the best possible outcome for the service recipient and his or her family. From 2002 till 2004, the MHSIP survey was mailed out to a stratified sample and yielded an averaged 23% response rate.

In 2005, DMHDD no longer used the mail out method to conduct consumer surveys. A paper survey was given to any willing service recipient with a scheduled appointment at any of twenty-two contract CMHAs within a twenty-day period. This significantly increased both the number of surveys completed and the response rate for 2005.

The 2006 survey included the “I am neutral” choice, which is thought to have negatively affected response rates for all domains. FY06 results for the other domains ranged from 85% to 93%, including 91% for family participation in treatment. Future survey results will be reviewed to determine factors that might have influenced this decrease.

For 2007, the survey was again done by convenience sample during a prescribed period of time but with responses entered directly into the TOMS web site. The regular TOMS consumer outcomes survey includes questions similar to those on the MHSIP in the Outcomes Domain. Responses will be compared to judge the validity of results.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To use TOMS data to determine school attendance rates of children and youth receiving publicly funded mental health services.

Target: Baseline number of days of school missed by children and youth service recipients.

Population: Children and youth receiving public mental health services and participating in TOMS.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of children with poor school attendance.

Measure: Numerator: Number reporting days of school missed on TOMS surveys during FY08.

Denominator: Total number of C&Y completing TOMS surveys during FY08.

Sources of Information: TOMS Survey, URS Table 19b

Special Issues: As TOMS is a new system, future performance indicators may be revised.

Significance: A goal of treatment is adequate role functioning for children and youth with mental illness or emotional disturbances. Attendance at school is a normal role for most children and youth.

Action Plan: For two previous years of the MHSIP annual survey, the following questions pertaining to school attendance and performance were added by DMHDD.
1) Was your child absent from school more than six days during the last school semester?
2) In the previous school year, was your child promoted to the next grade?

The question regarding the number of days absent was based on exceeding the allowable number of days absent according to state Department of Education regulations. While the rate of excessive absence increased from FY05 to FY06 (22% to 35%), so too did the number of children promoted (85% to 90%).

There are many factors that can influence both absence from school and promotion to the next grade; many of these factors may not be related to a child's emotional or behavioral problems. Over the same two years, an average of 85.5% of parents/caregivers responded "yes" to the statement: As a result of the services my child/family received, my child is doing better in school and/or work.

Perhaps the current URS criteria of suspension or expulsion from school to measure change in school attendance as a result of behavioral health services could be reviewed. Maybe questions that help to establish a more direct causal link between school attendance and a mental illness or emotional disturbance would better address the measurement of the desired outcome.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	0	N/A	N/A	N/A	N/A
Numerator	N/A	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To use TOMS data to determine how many children and youth report criminal justice involvement. Target: To determine a baseline percentage of the number of children and youth service recipients who have been arrested.

Target: Baseline percentage for TOMS data of children and youth service recipients who have been arrested.

Population: Children and youth receiving public mental health services and participating in TOMS.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of children and youth reporting at least one arrest.

Measure: Numerator: Number of C&Y reporting any number of arrests on TOMS surveys during FY08.
Denominator: Total number of C&Y completing TOMS surveys during FY08.

Sources of Information: TOMS Survey, URS Table 19A

Special Issues: As TOMS is a new system, future performance indicators may be revised.

Significance: Children and youth with mental illness or emotional disturbances are best served in the mental health system. One goal of treatment is to reduce the likelihood of behaviors that could lead to juvenile justice involvement.

Action Plan: DMHDD has no access to other databases to determine the arrest record of service recipients.

For the 2006 URS submission, criminal justice history was obtained through the annual MHSIP survey. Approximately 8% of children and youth with participation in services for at least twelve months responded “Yes” to the survey question: In the last year, did you get arrested by police or go to court for something you did?” For adults receiving services for less than twelve months, that percentage rose to over 15%.

The TOMS survey, begun in September 2006, is completed four times during the first twelve months of treatment. No pilot data is available for children and youth.

DMHDD supports eighteen criminal justice/mental health liaison positions serving twenty-three counties. While the liaison’s primary focus is on adults with SMI or COD, they do intervene in juvenile cases as requested. Efforts to streamline juvenile court assessments have not yet been implemented.

Staff from the DMHDD Office of Forensic Services regular consult with providers, judges and court officials regarding children and youth ordered for assessment and treatment through the juvenile justice system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	.86	86	87	N/A	N/A
Numerator	N/A	2,347	--	--	--	--
Denominator	N/A	2,738	--	--	--	--

Table Descriptors:

Goal: To promote social support systems for parents/caregivers of children and youth with mental illness or emotional disturbances.

Target: To increase by 1% the rating on the number of families who report positively on this domain.

Population: Caregivers of C&Y receiving publicly funded services and completing a MHSIP annual survey in FY08.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of persons submitting a positive survey response.

Measure: Numerator: Unduplicated # of individuals reporting positive response to questions in SC domain.
Denominator: Unduplicated # of individuals responding to SC domain questions

Sources of Information: MHSIP Survey

Special Issues: Similar questions on the TOMS will be compared for validity.

Significance: Social connectedness can help struggling parents, grandparents, or other caregivers feel less isolated and better equipped to deal with problem issues with their children and with providers.

Action Plan: DMHDD supports a variety of family support, advocacy and consultation activities targeted to promote support for families of children with emotional and/or behavioral disorders.

Pamphlets for various support groups are available in provider waiting areas, parent groups may be held at agencies in the evenings, and regional advocacy staff make presentations for parents, teachers and others on a routine basis.

Homogenous support, education, and self-help groups have long demonstrated an effectiveness at helping people feel that they are not alone, that there are things that work, and that there are others who understand and will listen and share what helps them. Adequate education and support for the parent or caregiver can enable a more appropriate response to the child's actions, decrease overall frustration, and instill a sense of hope within the family.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	68	70	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To provide behavioral health services to children and youth that result in increased functioning in role responsibilities.

Target: To attain an 70% rating on the number of families who report positively about improved functioning for their children.

Population: C&Y receiving publicly funded services and completing a MHSIP annual survey in FY08.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of positive survey responses on functioning domain.

Measure: Numerator: Unduplicated # of individuals reporting positive response to questions in functioning domain.
Denominator: Unduplicated # of individuals responding to domain questions

Sources of Information: MHSIP Survey

Special Issues: Similar questions on the TOMS will be compared for validity.

Significance: Improved functioning levels in school, with family and others is a sign of treatment success and enhances resiliency in the child or youth.

Action Plan: Previous MHSIP surveys distributed by DMHDD did not include all questions for the Level of Functioning domain. The FY07 survey will provide our baseline response, which we are projecting at the same level as that for the outcomes domain.

The TOMS youth and caregiver surveys contain similar questions related to functioning and will be used for compare for validity.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Stability in Housing

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	3.20	.02	N/A	N/A	N/A	N/A
Numerator	49	45	--	--	--	--
Denominator	1,545	2,759	--	--	--	--

Table Descriptors:

Goal: To determine how many children and youth receiving services report homelessness.

Target: Baseline percent via TOMS survey data.

Population: Children and youth receiving public mental health services and participating in TOMS.

Criterion: 3:Children's Services

Indicator: Percent of children and youth reporting homelessness.

Measure: Numerator: Number indicating a homeless choice as their living situation.
Denominator: Total number of youth and caregivers completing the living situation question on TOMS.

Sources of Information: TOMS Survey, URS Table 15

Special Issues: Not included in 2007 plan - no FY07 projection. Survey choices reported as homeless include shelter, on street, outside, or in a vehicle.

Significance: A goal of treatment is to engage persons in a recovery and resiliency process by enabling access to adequate housing options.

Action Plan: Data from URS Table 15 for both FY05 and FY06 were derived from the annual MHSIP survey. In both survey years, approximately 25% of persons reporting homlessness were under age eighteen.

For the FY07 URS submission, data will be collected from all TOMS surveys done during the fiscal year for comparison with MHSIP data. No TOMS pilot data is available for children and youth.

As TOMS is expanded to all CMHAs and more publicly funded individuals, these numbers will increase and be more inclusive. We will use FY08 as a baseline year to determine a more reliable number of children and youth served and to develop future measures.

DMHDD supports homeless outreach services in six areas across the state to identify and assist homeless families with children and youth.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Services for C&Y with Co-Occurring Disorders

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	80	79	80	80	N/A	N/A
Numerator	1,398	828	--	--	--	--
Denominator	1,733	1,044	--	--	--	--

Table Descriptors:

Goal: To ensure that children and youth with COD have access to appropriate services.

Target: To provide substance abuse services to 80% of children and youth with COD.

Population: Children and youth enrolled in TennCare diagnosed with SED and any substance abuse diagnosis.

Criterion: 3:Children's Services

Indicator: Percent of children with COD who receive a substance abuse service through the behavioral managed care system.

Measure: Numerator: Unduplicated # of children and youth under 18 receiving a substance abuse service.

Denominator: Unduplicated # of children and youth with a COD.

Sources of Information: DMHDD, Division of Managed Care

Special Issues: Data is for children receiving services under TennCare.

Significance: While integrated services is the optimal service goal, the ability to access appropriate inpatient and outpatient substance abuse services is critical for those with COD.

Action Plan: The Division of Alcohol and Drug Abuse Services documents services for persons under eighteen with a mental health diagnosis, but it does not specify those with SED for alcohol and drug services provided under the Substance Abuse Block Grant. The Division serves a minimal number of children and youth with a mental health diagnosis in treatment services apart from the managed care system. Therefore, data is for children receiving services under TennCare.

Providers are often reluctant to label children with a substance abuse diagnosis, but once diagnosed, appropriate treatment should be forthcoming. Numbers reported include those receiving an inpatient or outpatient service. Both the number of children and youth with a COD and the number receiving a substance abuse service decreased slightly in FY06. Access to substance abuse services not part of a CMHA may be limited by capacity. If integrated services are not available, priority will be given to issues related to the primary diagnosis.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Support for Early Intervention

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	23.58	22.80	22	20	N/A	N/A
Numerator	1,823,000	1,745,500	--	--	--	--
Denominator	7,730,700	7,647,500	--	--	--	--

Table Descriptors:

Goal: To ensure the availability of early intervention services for children and youth.

Target: To maintain a minimum of 20% of Block Grant funding for early intervention and prevention services.

Population: Children and Youth with SED, or at risk of SED

Criterion: 5:Management Systems

Indicator: Percentage of block grant funds being used for prevention and early intervention services.

Measure: Numerator: Amount to be allocated for prevention and early intervention services
Denominator: Total amount of block grant funding minus administrative costs

Sources of Information: DMHDD Office of Fiscal Services, Budget Allocation

Special Issues: Block grant allocations include BASIC and the Early Childhood Network.

Significance: Children and youth under eighteen comprise nearly 25% of Tennessee's population. Early prevention and intervention services are considered most important to avoid the development of more serious emotional and/or behavioral problems.

Action Plan: While supporting treatment, education, and other child and family support services, DMHDD is committed to a philosophy of prevention and early identification and intervention. The Department uses federal and state funding to support services aimed at prevention and the early identification of behavioral and/or emotional problems in children and youth. These include, but are not limited to, the programs outlined below.

o Child Care Consultation provides mental health training and technical assistance services to childcare, early childhood centers, and pre-kindergarten programs across the three Grand Divisions (East, Middle, West) of Tennessee.

o The Regional Intervention Program (RIP) is designed for the early treatment of families with children under six years old who have moderate to severe behavior disorders.

o The Early Childhood Network, a collaborative effort intended to provide a seamless and comprehensive system to identify and serve at an early age children in need of mental health services, by networking all local agencies who work with these children.

o Project BASIC is a school-based mental health early intervention and prevention service in which Child Development Specialists work with children in Kindergarten through Third Grade.

BASIC and RIP were developed in Tennessee more than twenty years ago and have expanded across the state. BASIC has been nationally recognized by the American Psychiatric Association and RIP has been extensively researched as a best practice. A number of states seek information, consultation, and training from Tennessee to replicate these programs.

For the current fiscal year, DMHDD will allocate a total of $4,929,217 to provide services for children and youth and their families. Of that amount, nearly 60% is allocated for the four projects described above.

Other identification and early intervention programs include homeless outreach to at-risk children or any age living in families that are homeless and a program of intervention for high-risk children of addicted mothers in a residential program.

Tennessee

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

MENTAL HEALTH ASSOCIATION
of East Tennessee
9050 Executive Park Dr., Ste 104-A • Knoxville, TN 37923
Phone: (865) 584-9125 • Fax: (865) 824-0040

August 23, 2007

Ms. LouEllen Rice
Grants Management Officer
SAMHSA
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

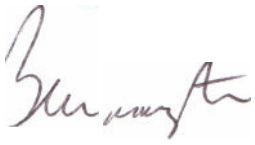
I am pleased to submit this letter in support of the 2008 Tennessee Community Mental Health Block Grant Plan. I want to thank you and SAMHSA for your continued support of important services and programs provided with Block Grant funding.

The Tennessee Department of Mental Health & Developmental Disabilities, together with the Tennessee Mental Health Planning and Policy Council and seven regional councils across the state, have worked hard to assess community needs and determine how best to utilize Block Grant funding. The community provides input via annual needs assessments and additional opportunities to review the Block Grant plan. All of this resulted in support of the plan at the most recent planning council meeting on August 17, 2007.

While pleased and quite proud of the diversity of programs, services and projects funded by the Block Grant, the Council is troubled by repeated cuts to this funding in past years. The Block Grants fund many valuable services across the country that assist people with mental illness in ways that Medicaid or Medicare services cannot. Now is the time to increase Community Block Grant Funding to enable states like Tennessee to expand great programs to serve more citizens all across the state.

Please feel free to contact me at 865-584-9125 should you have any questions in this regard.

Sincerely,



Benjamin T. Harrington
Executive Director

Chair
Tennessee Mental Health Planning & Policy Council

Tennessee

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.